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ABSTRACT

This study was undertaken to provide a descriptive analysis of the rhetoric of physicians (1) as they communicate with their colleagues, and (2) as they communicate with their patients. To accomplish the first objective, the oral presentations made during weekly conferences by the surgeons at a major hospital were observed for ten months. The rhetorical training, experience, speech philosophy, and preparation of each physician was considered as well as the occasion of the speech and an analysis of the audience. Each speech was evaluated according to its invention, structure, style, and delivery. The second objective of the study was reached by means of observations, interviews, and questionnaires. It was concluded that patients are willing to accept a surgeon's title as sufficient credentials to obey his directives without question. By the same reasoning, the surgeons themselves often seem to expect their colleagues to accept their judgment without asking for documentation. Most doctors will not disclose all possible information to the terminally ill or those scheduled for operations. The patients, however, report a desire for all details but, rather than asking questions, seem willing to wait for the surgeon to volunteer information. (Author/TS)

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THE RHETORIC OF PHYSICIANS: A FIELD STUDY OF COMMUNICATION WITH COLLEAGUES AND PATIENTS

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

in

The Department of Speech

by
Artie Yvonne Adams Thrash
B.A., University of Houston, 1969
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August, 1974

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ABSTRACT

The purpose of this field study is to provide a descriptive analysis of the rhetoric of physicians (1) as they communicate with their colleagues, and (2) as they communicate with their patients. To obtain the first objective the oral presentations made during weekly conferences by the surgeons at a major hospital were observed for ten months. The physicians' rhetorical training, experience, speech philosophy, and preparation are considered as well as the occasion of the speeches and an analysis of the audience. The speeches are evaluated according to their invention, structure, style, and delivery. The second objective of the study, an analysis of the communication between doctors and their patients was reached by means of observations, interviews, and questionnaires.

The results of this study indicate that the patients are willing to accept the surgeon's title as sufficient credentials to obey his directives without question. By the same reasoning, the surgeons themselves often seem to expect their colleagues to accept their judgment without asking for documentation. While the doctors are less hesitant in admitting mistakes and controversies concerning treatment to their colleagues than to their patients, they effectively reason that the patients' awareness of such problems would be detrimental to the patients' welfare. The surgeons demonstrate confidence in their own judgment before their colleagues and their patients but many of them lack the fluency and ease of

manner which usually accompany such self-confidence in their formal speaking.

The patients interviewed, for the most part, were satisfied with their communication with their surgeon. Explanations for this satisfaction included such characteristics as the doctor's "bedside manner," best illustrated by his demonstration of concern for them as individuals. The doctor gives verbal support to the principle that the patient has the right to know about his condition and treatment. Nevertheless, they are not always completely willing to disclose all possible information to the terminally ill, to some patients scheduled for operations, and under some circumstances, when a difference of opinion between doctors exist. The patient, on the other hand, reports a desire for all details but seems willing to wait for the surgeon to volunteer that information rather than to ask questions.

INTRODUCTION

The student of speech-communication frequently studies the rhetoric of the politician when, ironically, political leaders are held in low esteem by many people. On the other hand, the rhetoric of some of the most respected members of our society, physicians, is rarely an object of study. However, the scarcity of such material found in a search of the literature may be a result more of the physician's reluctance to be accessible for study by a nonmedical person than of any aversion on the part of a rhetorical critic. This hesitation might be explained in several ways: possible misinterpretation of his behavior leading to litigation; a fear of ethical violations of patients' rights; or simply a busy schedule that does not permit prolonged interviews or possible disruptions. Nevertheless, when communication is so important that it affects people's lives to the extent that a physician's rhetoric does, then it certainly is worthy of study.

The problem and its significance

The physician in contemporary culture probably is held in no less awe than the witch doctor in primitive culture, and enjoys some of the same mystique. One authority on biomedical ethics observes, "'Doctors' orders' are received with a subconscious sense of awe and respect which you don't necessarily give the mechanic at the

Ford garage, though his work is in some ways similar."[1] He sees this as a possible barrier to the communication the physician wants.

On the other hand, the following, equally disturbing communication barriers, are listed as problems in physicians' public relations by Richard Blum:

> 1. The public image of doctors as the people in our society who have the best jobs, the most prestige, power, and money exposes physicians to popular envy and to intense public criticism as a result.
>
> 2. The popularizing of medical science success and of the skill and self-sacrificing humanity of physicians has oversold the public on scientific accomplishment and on the super human benevolence of the individual physician.
>
> . . . .
>
> [illegible]. The image of the medical profession as a clan or fraternity bound by internal solidarity to protect its erring members from public scrutiny or punitive action has led to public resentment and distrust.[2]

One result of these problems is a very real fear of malpractice suits, or other legal involvement, which the doctor realizes would be time consuming, create financial problems, or seriously endanger his professional reputation. An example of such a possibility was related by one surgeon as he told of a local doctor who was involved in litigation over a failure to diagnose a specific illness when the patient, during office visits, had never mentioned any problems symptomatic of that illness. The court judged that he was not guilty of negligence, but because he was more financially able to assume the costs, he was ordered to pay for the patient's subsequent treatment.[3] Incidents such as these contribute to the reluctance of many doctors to discuss their professional practices with patients and other laymen.[4]

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[1] Bruce Hilton, "Patients' Liberation," Houston Chronicle, October 21, 1973, Zest section, p. 1.

[2] The Management of the Doctor-Patient Relationship (New York: McGraw-Hill Book Company, Inc., 1960), p. 293.

Another view, however, is that better communication between doctor and patient would reduce such legal entanglements.[5] An interview with one patient in this study revealed that he was sueing his previous doctor, but when questioned about the reason, he would say only that "his whole attitude was bad."[6] It would be difficult to believe that doctors have remained unaware of what one physician sees as a society that is "progressively more knowledgeable about its birthright of 'good medical care.'"[7] He attributes this "greater insight and increasing ability to understand medicine" to the following:

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[3] According to the interviewed surgeon, the physician's insurance company frequently settles cases out of court for a variety of reasons, one of which is the impossibility of proving that no human error was committed at any time by the doctor in his treatment of a patient.

[4] Surgeons are considered high risk groups by malpractice insurance companies; for additional comment on high risk, see "Communication Gap can Touch off Avoidable Suits," Houston Post, Sept. 30, 1973, sec. DD, p. 1; see also Stephen Lewin, ed., The Nation's Health (New York: The H. W. Wilson Company, 1971).

[5] "Communication Gap can Touch off Avoidable Suits," p. 1.

[6] The patient seemed to feel that this was especially "bad" because both he and the doctor were members of the same ethnic group; the interview was in connection with Part II of this study.

[7] John H. Knowles, ed., The Teaching Hospital (Cambridge, Mass.: Harvard University Press, 1966), p. 85.

> Every major newspaper and popular magazine has its own or a syndicated medical columnist; home medical manuals and dictionaries abound; hardly a day goes by that the citizen isn't bombarded by information and advice regarding his health wants and needs; television sends its beam of psychiatry, neurosurgery, and aspirin into every American parlor and bedroom; and every citizen reads the medical fund-raising material of a hundred maimers and killers.[8]

This information from the news media might be misleading and has resulted in what could be called pressphobia, i.e., a fear of talking to the press. An example of the type of sensationalism that physicians would like to avoid is seen in the following newspaper headline during the spring meeting of the American College of Surgeons in Houston: HARVARD SURGEON REPORTS STARVATION IN HOSPITALS.[9] The subject actually was the need for more nutrients being included in intravenous solutions.

On the other hand, therefore, is a more knowledgeable public who is also more consumer oriented. He demands the best for his money; he wants to know what he is getting. On the other hand is the doctor who is fearful of the results of being misunderstood in communicating with that public.

Some laymen attribute the lack of communication to the use of unnecessary, professional jargon, of "medical terminology." To others, the use of a "coded language" such as the excessive use of abbreviations symbolizes superior knowledge. Unquestionably, most patients do not have the medical knowledge of their physicians but it is probable that most wish to understand their own illness and treatment. However, the question is, under what circumstances is total comprehension necessary or desirable in communication between doctor and patient?

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[8] Ibid., p. 85.

[9] Moselle Boland, Houston Chronicle, March 28, 1974, sec. 1, p. 13.

Nevertheless, the physician should not have the same difficulties in communicating with his colleagues once the emotional, legal, or educational barriers or influences associated with patients have been removed. That is, when no laymen are present, the doctor should be able to discuss freely a diagnosis,.controversial alternatives to treatment, and possible human errors committed by physicians. Thus it is postulated that physicians' oral presentations should not differ in the rhetorical canons from other professionals' public speeches if the audience and speaker are all members of the same profession. That they all share certain training and expectations is illustrated in the observation of John H. Knowles, a noted physician, who states that a doctor is unique as an individual because he is trained to a "highly individualistic role, to take immediate action, to give orders which must be followed, and to expect immediate rewards."[10] Richard Blum believes that the doctor's role is influenced in part by his being given priority when communicating.[11] For example, the patient and doctor both speak to the nurse at once and the nurse will answer the doctor, not the patient; if the patient is talking to the doctor and another physician calls to the conversing doctor, the latter will interrupt the patient to speak to his colleague.[12] What happens when this highly individualistic, perhaps authoritarian, personality attempts to communicate with others who have experienced the same ego-building reinforcement?

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[10] P. 88.

[11] P. 223.

Other questions considered in this study include the following: Is there a "medical style" of communication? How does extensive medical training affect the organization of the physicians' speeches? Does the doctor exhibit a high degree of self-confidence in delivering his presentations? The answers to these and other questions not only should enhance knowledge of the rhetoric used by some of the most influential members of our society, but also create an awareness of the problems which the doctor encounters in oral communication.

Therefore, the purpose of this study, specifically, is to provide a descriptive analysis of the rhetoric of physicians (1) as they communicate with their colleagues, and (2) as they communicate with their patients.

Methodology

The method used in this investigation is primarily that of a field study. Fred Kerlinger states "the investigator in a field study first looks at a social or institutional situation and then studies the relations among the attitudes, values, perceptions, and behaviors of individuals and groups in the situation."[13] These studies are of two broad types: exploratory and hypothesis-testing.[14]

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[12] Ibid.

[13] Foundations of Behavioral Research (New York: Holt, Rinehart and Winston, Inc., 1964), p. 387.

[14] Ibid., p. 388.

Kerlinger defines the exploratory type as seeking what is, rather than predicting relations to be found. This study is primarily an exploratory study of physicians as they communicate in the field of medicine.

Roy Carter suggests any of the following tools for use in field studies: (1) direct observation of behavior; (2) the interview; (3) the self-administered questionnaire; and (4) any combination of the three.[15] This study utilizes a combination of the suggested forms.

Direct observation has been used to accomplish the first purpose, that of studying the communication among physicians. The individuals who participated in the study are physicians, primarily surgeons, affiliated with St. Joseph Hospital, a large teaching hospital in Houston, Texas, which is associated with the University of Texas Medical School. For this analysis, the investigator attended scheduled weekly conferences for a period of ten months. These conferences, held each Saturday morning at 7:30 at St. Joseph Hospital, generally begin with a case presentation by one of the residents, followed by a response given by a private physician who is considered an "authority" on the particular topic for the conference. Occasionally, the entire conference is devoted to hearing a guest speaker from another hospital or institution on a special topic of interest.

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[15] "Field Methods in Communication Research," in Introduction to Mass Communication Research, ed. by Ralph O. Nafziger and David M. White (Baton Rouge: Louisiana State University Press, 1963), p. 80; see also, Ernest Bormann, Theory and Research in the Communicative Arts (New York: Holt, Rinehart and Winston, Inc., 1965).

The sessions end with a question and answer period. The audience consists of between twenty-five and fifty resident and private physicians and, occasionally, a few other medical personnel.

In analyzing the speeches, the writer has followed the principles set forth in Parts IV and V of Speech Criticism by Lester Thonssen, A. Craig Baird, and Waldo W. Braden.[16] The physicians' rhetorical training, experience, speech philosophy, and preparation are considered as well as the occasion of the speeches and an analysis of the audience. The speeches are evaluated according to their invention, structure, style and delivery. The presence of an observer-critic, of course, possibly affects the speaking situation. From the beginning, the resident doctors knew of the presence of a nonmedical critic and sometimes made references to the fact. One means of gaining access to these conferences was by an agreement that the residents would receive constructive criticism for improving their speeches. Details of this agreement are discussed later in the study as part of the speaker's preparation. The private physicians became aware of the investigative role as the need for interviews and further cooperation became apparent. That the investigator was permitted to attend the conferences and given interviews was primarily a result of the chief of surgery's recommendation to the president of the hospital and by his verbal support of the study to his colleagues. Over a period of time the presence of an observer came to be taken for granted.

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[16] (Second ed.; New York: The Ronald Press Company, 1970), pp. 305-46.

Tape recordings were made of the earlier presentations, but the possibility that this might hinder the freedom of the physician's speaking necessitated their discontinuance. Subsequent speeches were recorded in the author's own style of shorthand and reviewed immediately after the presentation with additional notes and comments. Any questions concerning content of the speeches were answered either by the speaker or by the academic chief. This is not to say, however, that the critic had sufficient medical knowledge to serve as an accurate judge of the validity of some arguments and such an attempt is not made in this study.

The second focus of the study is on communication between doctors and their patients through observation, interviews, and questionnaires. Subjects were the same physicians who were conference speakers, and two "types" of patients. The first interviewed were patients using the hospital clinic where they were treated by resident doctors. These patients are, for the most part, charged according to their ability to pay. No one patient has a specific doctor in charge of his case. These and other differentiating characteristics are discussed in the analysis. The second type of doctor-patient relationship was between the physicians on the hospital staff and their private patients. The data for this portion of the analysis were more difficult to obtain. That is, while doctors are willing to have "charity patients" serve as objects of study, they are reluctant to have their paying, private patients interviewed. One surgeon agreed, at first, to allow his patients to be interviewed only if he could select the patients. He later agreed to remove this restriction. Reasons for this hesitation have already been explored. After repeated assurances that the interviews would not attempt to violate the ethical relationship between the doctor and patient, the research continued. Details of the exact procedure, number of subjects, and questions used during interviews are given in the second part of the study.

The final summary includes an evaluation and comparison of the oral communication of the physician as he speaks with his colleagues and his patients. Consideration is given to how the doctor adapts his rhetoric to fit the needs of two different types of listeners.

Contributory studies

Three works have significantly influenced this study. The first, "Communication from Attorney to Client" by Wayne Thompson and S. John Insalata, provides a general overview of the kinds of communication barriers that exist between a member of a specific profession dealing with human problems and a layman.[17] The analysis is based on the responses to questionnaires mailed to attorneys. The authors note the following barriers to communication in an attorney-client relationship: (1) an overall disturbed emotional state within the client; (2) emotional blocks on a particular point (the client listens for information which appeals to him and neglects to comprehend that which is distasteful); (3) preconceived notions (prior opinions interfere with decoding the message);

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[17] The Journal of Communication, XIV (March, 1964), 22-33.

(4) divergent views as to the role of the attorney; (5) inadequate reinforcement and insufficient time for grasping thoughts; and (6) inaccurate and inadequate referential meanings.[18] Because there seem to be similarities in people who are seeking help from a highly trained specialist, some of the same communication problems in the legal field probably exist in the medical field.

A second study, Life in the Ward by Rose Laub Coser, examines the process by which the patient adapts to the society of the hospital ward.[19] Included in the data is material concerning patients' relationships with the staff doctors. The primary value of this study to the present one lies in the research approach with physicians and hospital personnel. The author reported instant, excellent rapport with the hospital nurses but an initial "cold" reception by the interns and residents on the surgical floor. While this attitude by the house staff changed, the senior surgeons only "tolerated" the author's presence, considering the study of little importance.[20]

Some of these difficulties were remarkably similar to ones encountered in the present study. The hospital nurses were extremely helpful in supplying an office in which to interview clinic patients privately and even providing an interpreter when a language barrier was present.[21] They were interested in supporting anything that would improve communication with physicians. The reason for this seems to be a protective and an almost familial identification of the nurses with the patient as compared with the objectivity--sometimes interpreted as unconcern--of the doctor.[22] Unfortunately, most of the office nurses, or secretaries, of the private physicians cooperated only under pressure. They seemed to consider their role as providing a protective barrier around the physician. This behavior may or may not have been encouraged by the physician. The hostility either to the study or to the investigator was so great in one person that she neglected to tell the doctor of the presence of the researcher in the waiting room until it was too late to complete the research for that day. Connecting doors are kept locked. While these office nurses also saw themselves as being an essential liaison between patient and doctor, they frequently only added another step to the communication process and sometimes their attitude disrupted the flow completely. The question, of course, arises as to the extent to which the attitude of the physician toward both the observer and his patients influences the attitude of his office staff.

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[18] Ibid., 25-29.

[19] (East Lansing, Mich.: Michigan State University Press, 1962).

[20] Ibid., p. xxi.

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[21] Many of the clinic patients are Mexican-American but only four could not speak English. While not fluent in Spanish, I could understand enough to assure that the interpreter was giving an accurate translation. During one interview, the patient was asked if she had been able to find out everything she wanted to know and she answered "no." This answer seemed to disturb the interpreter and she rephrased the question but the patient was adamant.

[22] The hospital nurses recently had been involved in management training classes which caused them to deplore the lack of similar training for the physicians, but a better explanation of the relationship between the nurses and patients is illustrated by the action of the nurse who picked up a patient on her way to work and returned the child on her way home so that the little girl could be treated in the outpatient clinic.

The third contributory study, Human Relations and Hospital Care by Ann Cartwright, provided many of the questions used in Part Two to study communication between the doctor and his patient.[23] The Cartwright study was especially useful in providing statistics concerning patients' desire for information and their sources of information. Subjects for that study were English and Welsh hospital patients. A structured questionnaire was used by several interviewers who called on the subjects after they returned home. The present study is not an attempt to replicate the Cartwright study using American subjects, but some of the same problems in communication are considered.

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[23] (London: Routledge & Kegan Paul, 1964).

PART I. SPEAKING WITH COLLEAGUES

Physicians function in more than one role in their profession. Not only do they treat the ill, their obvious role, but they also must act as administrators in finance and management and instructors to physicians and staff personnel. They must serve on numerous committees in the hospital and professional organizations; they must be researchers and students as well as educators. Frequently their reputation is based more on their performance of other roles than on the treatment of the ill. Most of these roles require the ability to be an effective communicator.

A survey of one surgeon's appointment book reveals some of the responsibilities other than seeing seven to twelve patients in his office two days a week, operating three days a week, and making hospital rounds every day.[1] These additional meetings for the first two months in 1973 included the following:

1-18-73	Lecture to Medical Skills Learning Unit
1-19-73	Attend Publications Committe Meeting
1-26-73	Attend American Cancer Society's National Crusade Kickoff
1-26-73	Journal Club Meeting to discuss medical literature
2-2-73	Attend Tumor Conference
2-5-73	Lecture to University of Texas Medical School
	Attend General Surgery Meeting
	Attend Cancer Society Executive Committee Meeting

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[1] The number of private patients seen by a physician in one day may vary according to the doctor's schedule. Another of the surgeons sees approximately forty patients in his office two days a week and operates the other three days.

2-16-73 Attend Clinic and Conference

2-19-73 Attend Medical Research Committee

2-21-73 Lecture to the "Quit Smoking" Clinic

2-24-73 Participate in Coagulation Seminar.

Regularly scheduled weekly seminars and conferences with residents and interns were also held, and the third and fourth months of the year included several press conferences and one television appearance in connection with the American Cancer Society.

Active membership in organizations such as the following are considered an essential means of providing a continuing education for the surgeons at this hospital:

Houston Surgical Society
Texas Surgical Society
American College of Surgeons
John Paul North Surgical Society
American Cancer Society.

Other specialists, such as plastic surgeons or cardiovascular surgeons, have additional organizational memberships.

These activities and responsibilities are illustrative of the regular communication between a physician and his colleagues. However, for the purposes of this study, only the surgical Grand Rounds Conference was selected for analysis as it is representative of most of the occasions during which the physician is speaking to his colleagues. This weekly conference is scheduled regularly for Saturday mornings, is well attended and stimulates considerable participation.

The first chapter is an analysis of the setting for these conference speeches, which includes a discussion of the purposes for the conferences, the physical setting in which the speeches are given, and the audiences for the speeches.

Chapter Two provides insight into the physician's role as a speaker. Included in this chapter are summaries of the surgeon's medical and speech training and experience that help prepare him as a speaker and his immediate preparation for a conference speech.

A critical evaluation of the conference speeches appears in the third chapter. A description of the organizational methods used by resident and private physicians is included as well as an explanation of how topics for the speeches are selected and amplified. The speakers' style and delivery of the speeches also are described and evaluated in this section.

CHAPTER ONE

THE SETTING FOR CONFERENCE SPEAKING

Various types of hospitals exist to treat people who are sick and injured but a teaching hospital has additional responsibilities. John H. Knowles, M.D., in writing about the function of the teaching hospital notes that it has the responsibility for the "conservation and expansion of knowledge through educational endeavor and scientific research."[1] He gives the following means of fulfilling these obligations:

> The teaching of medical students; the postgraduate training of interns and residents; the support of schools for nurses, dieticians, medical record librarians, physiotherapists, X-ray and laboratory technicians; the conduct of postgraduate "refresher" courses for practicing physicians and teaching conferences open to all physicians on a regular basis; the publication of clinical experience and research findings and the further sharing of knowledge as visiting lecturer, all round out the activities of the teaching hospital and its staff.[2]

The hospital cooperating in this study meets the above responsibilities in a variety of ways, among which are a nursing school, medical records classes, and the publication of a medical journal. One means of enhancing the educational function is the practice of holding a Grand Rounds Conference. The speeches given during this conference are the ones chosen to illustrate the physicians' speaking with their colleagues on a formal basis.

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[1] The Teaching Hospital, p. 101.

[2] Ibid.

No longer does the medical team--the private physician, chief, residents, interns, and medical students--go from bed to bed discussing patients as a learning technique for the lower echelons. Instead, each division such as surgery or internal medicine meets once a week under the direction of the chief of that division. The conferences of the department of surgery were selected for study for no reason other than the surgeons expressed an interest in their problems in communication. The number of conferences studied include the weekly meetings held between July, 1973, and April, 1974.

Purpose of the conference

The avowed purpose for the weekly conference is for the dissemination of information. However, there are other purposes, some hidden and some stated, that are considered in the discussion of the speeches. In some respects, the conference is similar to many graduate seminars. That is, a resident is responsible for presenting factual material concerning a specific case such as what was discovered in the initial physical examination of a patient, his history, and his chief complaint. After this brief résumé, the speaker reveals some knowledge of the literature in citing other reported cases. Since it is the group of residents who are required to attend, it is that group which should be the greatest beneficiary. However, the conference also is a means for the private physician to keep abreast of current developments in medicine. After one conference when a younger surgeon complained of the senior staff members as being unreceptive to new ideas or new methods of treatment, he was told by another surgeon that the conference was a good method of exposing such ideas to all of the doctors while allowing the more experienced ones to offer arguments for older, more established methods. In this way, both newer members of the profession and older ones benefitted.

Physical Setting

The surgical conference is held every Saturday morning at 7:30 in the hospital's conference room, which was designed for adaptability with folding tables and moveable chairs. Unfortunately, the speakers have not utilized this flexibility to its best advantage. Since the room is used during the week, the arrangement on Saturday morning varies from time to time. The speakers thus are faced with a different type of arrangement each week for their conferences.

The most frequent arrangement is with the chairs grouped around the banquet-type tables. Unfortunately, this is the worst arrangement for these conferences. One problem exists during the use of slide, movie, and opaque projectors because some members of the audience have to sit behind the equipment. The audience tries to solve another obvious problem by not sitting around the front side of the tables with their backs toward the speaker. This leads to a shortage of chairs, especially for the latecomers. The final problem is the interruptions by latecomers and emergency calls during the meeting. The large number of doctors who arrive late create a crowded condition around the door, and the two to six who receive calls via the "beeper" system during the session are a further distraction as they attempt to walk from around the tables to the telephone or leave. Many of these problems could be reduced or eliminated by each speaker as he arrives early to set up his equipment for the visual aids. He sees to it that the necessary machinery is there and that the coffee urn is in readiness, but he does not alleviate the awkwardness of the seating arrangement. The obvious solution would be to eliminate the tables and arrange the chairs in rows with a center aisle for the equipment and side aisles for easy accessibility.

The physical setting has another drawback to meeting the needs of these speakers. No speaker during the ten month period has failed to ask that the lights be turned off and on, from one to five times, during the speech for the showing of slides or X-rays. This requirement necessitates someone in the audience being responsible for this action. Since this request has not been arranged prior to the speech, more than one person frequently sees the need at the same time and there is further distraction as several people attempt to comply with the public request. Ideally the speaker should be able to use a light switch that could be connected to the podium since this action is such an integral part of all the speeches.

The conference room has the potential for being the best physical setting for this type of public speaking. For the most part, it is the speaker himself who fails to utilize its potentiality. At best he is talking to an audience that is being distracted by beep-beep signals from pocket transistors and static voices requiring a telephoned response or declaring some emergency. He does not need further problems caused by awkward seating arrangements.

Audience

The audience for the surgical Grand Rounds Conference usually consists of between twenty and forty physicians, depending on the importance of the topic or the reputation of the speaker. The composition of a typical conference is about forty percent resident doctors, fifty-five percent private physicians, and five percent medical students, interns, and technicians. Only the residents are required to be present; however, the frequent attendance of most of the general surgeons on the hospital staff is expected. The conferences are open to the nurses as well as the physicians but only once did any attend and it was by specific invitation.

The male-female ratio at a meeting is never less than ten to one. The hospital has three female residents but all three are rarely present at any one time; and never did any female private physician attend a conference during the period under study. The usual conference has one female doctor, if any.

The audience is predominately White, Anglo-Saxon, and Protestant. The last characteristic is ironic since the hospital's administration is under the authority of a Catholic order of nuns. Of the minority groups usually represented, three are Blacks, six to eight are from Mexico, and one is from Iceland, and one is Jewish.

Only once during the period being studied was a patient present at the surgical Grand Rounds. He was requested to attend in order to answer questions about his feelings and attitudes following an operation in which a certain amount of intestinal tract had been bypassed for the purpose of obtaining a reduction in weight. He was not allowed, however, to remain during the entire conference. After he assured the doctors that he was feeling well, admitted that the known complication of such an operation (diarrhea) was uncomfortable but bearable, and that he considered the operation to be a success (his romantic relationship with girls had improved), then he was asked to leave.[3] His presence, therefore, did not create a hindrance to the speaker's freedom. One surgeon expressed the reasons for not allowing this patient, nor any patient, to hear a presentation of his case as being that (1) no one in the audience would feel free to criticize his colleague's treatment of the case for fear of motivating a malpractice suit, and (2) it is not in the patient's best interest to be made aware of possible controversies concerning his treatment.

The characteristics of the physicians as members of the audience and the physicians as speakers are, of course, indistinguishable for the most part. The audience shares the same general appearance, training, and experience as the speaker. Perhaps there are some inherent problems in speaking to a homogeneous group, especially one in which the speaker is also a member. Probably the greatest of these is meeting audience expectations. The speaker has a difficult time in being the best informed person present and in deciding what material he should select for presentation because someone else always seems to know a case which was an exception to what had been stated or to have read a more current article contradicting the speaker's view. The members of the audience are unwilling to allow any erroneous information to stand, which, of course, is an excellent safeguard considering the possible result. Examples of this include a speaker using the term intraluminal for interluminal and being corrected immediately and a disagreement over carcinoid tumors because the speaker was describing one stage and the other physician was talking about a later stage. Sometimes these expectations become assumptions, i.e., the audience assumes the speaker, as a physician, is well informed. The important point is that the audience is hesitant to listen to anyone unless he is also a physician.

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[3] He has not been invited to speak recently since he has had subsequent problems.

CHAPTER TWO

THE PHYSICIAN AS SPEAKER

The speakers at the Grand Rounds Conference might be affected by training or personality traits that seem to be associated with the surgical discipline. For example, Coser found the following differences in the atmosphere and decision making between medical wards and surgical wards:

> . . . in the medical ward, students and junior house officers must be taught to *think* and *reflect*, while in the surgical ward the emphasis is on *action* and punctual performance. Admittedly, this seems an excessively sharp distinction, and ideally surgeons should learn to think as well as act. Yet the distinction is a real one. Doctors have a clear image of the fundamental difference between medical and surgical men. Doctors on the medical ward, asked why they chose their field of specialization rather than surgery, tended to reply: "Medicine is more of an intellectual challenge," or "I enjoy the kind of mental operation you go through," or "Surgeons want to act and they want results, sometimes they make a mess of it." The doctors on the surgical ward agreed, although they gave a different evaluation of the same descriptive traits. They said that they chose to be surgeons because they "like working with their hands," that they "prefer something that is reasonably decisive," and that "a medical man probably doesn't want to work with his hands."[1]

The fact that the physicians participating in this study are all surgeons is a result of circumstance.[2] This limitation, however needs to be realized before generalizations are made concerning all physicians or other specialists.

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[1] *Live in the Ward*, p. 136.

[2] The Chief of Surgery became interested in problems in communication after one of his surgical nurses enrolled in a university speech class. He offered his support which was essential in gaining hospital approval for this study.

Interviews with the surgeons during this study tend to support the difference theory. One doctor suggested that any physician could walk into a group of doctors and decide the speciality of each on the basis of his personality alone. Several agreed with this statement and mentioned that surgeons have a certain "personality"; one doctor cautioned the "you should realize that a surgeon is a different type of person." The ambiguity of the word "personality" was never reduced. That the surgeons themselves readily admit a difference between their own personality and that of other specialists suggest that they encourage and admire traits or characteristics held by members of their special field. It seems safe to assume, therefore, that the speakers demonstrating this "surgical personality" meets certain expectations of their audience.

Nevertheless, the surgeons cannot rely entirely on their surgical ability or personality to gain acceptance for their ideas. Some type of preparation precedes their conference speaking. The answers to the following questions concerning their formal or informal preparation provide insight into the speeches: (1) How does the surgeon's medical experience contribute to his speaking ability? (2) How does the surgeon develop training and experience in public speaking? and (3) What constitutes the surgeon's immediate preparation for formal speaking?

Medical experience

The following brief explanations of the terms used in this study to denote the status of doctors also will clarify the medical experience which the physician has obtained.

An intern has completed medical school and is serving a year's in-service training at the hospital. He is considered a member of the "house staff."

A resident has completed his internship and is specializing in in-service training for a specific field such as surgery or internal medicine. A distinction is made according to which of the four years of residency the doctor is completing, e.g., a third year resident has a higher status than a first year resident. The resident also is part of the house staff.

A chief resident is a fourth year resident who is in charge of schedules and appointments for the residents and is the liaison between the residents and the academic chief. The designation usually rotates every three months among the fourth year residents.

A surgeon has completed four years as a surgical resident. A further distinction is made for surgeons who complete another one or two year residency in a specific surgical specialty such as plastic surgery or cardiovascular surgery.

An internist has completed his residency in internal medicine. Some competitiveness exists between internists and surgeons.

The term private physician is used in this study to designate any internist, surgeon, or general practitioner who maintains a private practice.

An academic chief is head of a specific area of specialization such as Chief of Surgery in the teaching hospital.

The Chief of Staff is the highest medical officer in the administrative hierarchy. The highest administrator is the President of the hospital.

As the physician's medical experience increases, so does his status as a speaker. The result of this higher status is a change in his audience's expectations. The speakers from the lower echelons, for example, are expected to demonstrate a knowledge of the medical literature when speaking, while the private physicians enjoy credibility based primarily on their experience. An example occurred after a presentation on peptic ulcers during which the controversy over whether treatment should be surgical or non-operative was considered. One private physician felt that even though he "was not really in favor of nonoperative treatment of perforated ulcers," he did not think the speaker "put it in the proper perspective on the basis of current literature." He proceeded to mention a study more recently reported than any used by the speaker. Ironically, since the study did not support what he himself believed, he probably would not have used it in a speech of his own. Nevertheless , controversies concerning treatment do exist, and both the resident and private physicians have to be able to support their own views without alienating their colleagues.

The speaker's preparation

The preparation of a particular conference speech usually begins when one of the surgeons becomes interested in a patient with an unusual or complex illness or injury. Obviously, part of the doctor's acquisition of knowledge about his subject comes from the actual treatment and progress of the patient, but the formal preparation primarily is a search through the medical literature for relevant information. The extent of this literature search varies with the doctor, of course, and with his purpose. That is, if the subject is complex or controversial, he will be more thorough than usual in his research so that his conference presentation might also result in a speech for other groups or in its publication in one of the medical journals.

Frequently, however, it is only one or two days before the surgeon is scheduled to speak that he hurriedly tries to collect all his data and material. Because of the heavy reliance on the use of slides and other visual material, the doctor's last minute preparation creates a problem for the audio-visual department.[3] The speaker provides the department with the information or pictures he wants placed on slides, but if there is insufficient time for this to be done, he will type his own material and use an opaque projector. If a speaker has recognized a potential conference case as it occurred, he will have had the audio-visual department provide him with the proper equipment for making movies or slides of the actual operation. Because of the department of surgery's insistence on filming a large percentage of their operations, the speaker usually has little problem in obtaining these.

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[3] Most large hospital have a talented and well equipped department of visual aids. Some employ artists trained in medical drawings but all make their own movies and slides for the projection machines. The doctors become adept cameramen and projectionists although the department will furnish the personnel if it is requested.

Most of the doctors are willing to amplify and expand their material but most of them are reluctant to eliminate any. One surgeon became so interested in problems associated with automobile accidents that he wanted to include additional information related to the interests of the new audience, but refused to omit any of his previous material. When asked to speak at the conference again, he gave a two and one-half hour speech. His preparation had not included any editing and eliminating of material.

Speech training and experience

Whatever formal speech training a doctor receives is in public schools or as an undergraduate college student. If he takes speech-communication courses, it usually is of his own volition because many universities do not require speech for science majors. Of the doctors interviewed during this study, only two mentioned specific course work in oral communication and one of these recalled a junior high school class in speech. Whereas nurses are becoming more concerned and participating more frequently in in-service training in interpersonal communication, the doctors rarely concern themselves with such responsibility. No course work in any area of communication is given in medical school, or for interns or residents. However, some physicians see the need for improvement in their public speaking and arrange for special seminars or consultants to work with them. For example,the academic chief of surgery for the residents participating in this study became dissatisfied with the presentations being made during the Grand Rounds Conference and obtained a financial grant to provide an instructor for training this group in public speaking. Because this extra medical training in speech might have had an influence on the speaking of some of the surgeons, a brief summary of the course work and activities follow.

The instructor gave lectures on the following topics: analysis of audience and occasion; preparation and organization of presentation; utilization of support material and visual aids; oral style; semantics; modes of delivery; and voice, diction and bodily movement. The residents video taped several of their own ten-minute speeches and these were replayed for criticism from their colleagues and the instructor. At a few of the sessions the surgeons participated in impromptu speaking on hypothetical questions and in role playing for problem-solving. The sessions were attended by approximately half of the residents but the same residents were not always present. During the period of this study the instructor has acted as a critic of the residents' case presentations at the Grand Rounds Conference. The influence of the critic, if any, seems to have resulted unintentionally in slightly more concern with delivery rather than content. Probably this emphasis is because the resident doctors are unlikely to consider a nonmedical critic as being knowledgeable of medical subjects. Criticism of the speakers' organization, documentation, or need for amplification often resulted in irrelevant rationalizations such as, "I didn't know I was going to be the speaker until two days ago," and "I had an emergency and didn't get to work on it," or "But this case was different and citing sources isn't necessary." And, of course, as sometimes happens when offering critiques, at least one was met with hostile silence.

With little or no formal training in oral communication, the private surgeon learns through experience. As a resident, he is responsible for making case presentations. After entering private practice he becomes a staff member of from one to three hospital, where he speaks at Grand Rounds Conferences, and, as he develops a reputation in a special area, he is invited to speak at various hospital conferences and other professional seminars and conventions. If he is a successful, effective speaker, he may also be invited to speak to lay groups.

In a survey of sixteen of the surgeons participating in the Grand Rounds Conference, this question was asked: "Approximately how many speeches, lectures, or symposiums a year do you present to your colleagues?" Only three of the sixteen answered "none"; and three responded "over ten." Another two answered "one or two," while the remaining eight gave answers which indicated a variation from three to ten times a year. When a similar question was asked concerning the number of speeches given to laymen, or nonmedical groups, the responses were again, three answering "none," and three "over ten." The fact that two of the surgeons had answered "none" for both questions might indicate that they either misunderstood the question or have an aversion to public speaking. It is possible that they have no opportunity but highly improbable. One of the three who gives over ten speeches a year to his colleagues also gives an equal number to nonmedical groups. He further stated that he "was always speaking to something." In order to ascertain that the speeches to nonmedical groups nevertheless were connected with the role of physician, the doctors were asked how many of these speeches are nonmedical in subject matter. Eleven surgeons said that all of the speeches had medical subjects, and the remaining two said only "a few" were nonmedical in subject matter. Granted that all of these questions might be interpreted in more than one way, the results clearly show that public speaking is an integral part of the physician's professional life.

CHAPTER THREE

THE SPEECHES

The Grand Rounds Conference basically is composed of three major parts: the case presentation, the substantive speech, and a general discussion. In essence, the first is a brief informative speech by a resident; the second is a more comprehensive presentation of the conference theme; and the last is a question and answer period involving the audience and speakers. Both the case presentation and the substantive speech are examined thoroughly to determine how the structure of the speeches, their content, their style, and the speakers' delivery of the speeches were used to accomplish the physicians' purposes.

Purposes

Although the avowed purpose of the conference is educational, or for the dissemination of information, the speeches themselves serve other purposes as well. Basically, the purpose for the residents' speaking is to meet one of the requirements of the department of surgery. Although the primary purpose for all the speeches is said to be informative, persuasive elements are present. For example, one resident advocated hyperalimentation as a preoperative treatment for a large percentage of patients. This treatment was being used successfully at another of the large hospitals in the medical center. A skeptical attitude seemed to exist the first time the suggestion was made in a conference speech and jokes were made about this treatment being a panacea for all things. In a later conference, therefore, the doctor had a persuasive purpose in presenting a case in which hyperalimentation had produced impressive results; he was followed by a guest lecturer from the other hospital who showed films and slides of this treatment being successfully used in pre- and post-operative care in a series of cases.

Several hidden purposes also exist for the individual speaker. Of course, most of the resident doctors seek to make a presentation which will indicate their dedication and knowledge. Sometimes the private physicians and guest lecturers also are trying to build their reputation through speaking. In no case, however, is the doctor's purpose one of seeking consultation for the better care of a particular patient. The presentation of a patient's case is made after he has recovered, been transferred, or died. During the period of this study, the cases were presented from three months to a year after the patient had been hospitalized.

A secondary purpose sometimes seems to be a desire to win recognition or praise for the speaker's care of the patient. The doctor rarely expresses doubt as to which of the possible treatments was the best in that case. He has confidence in his own judgment, which should be self-evident. That is, he would not have used that particular treatment if he did not think it was the best. However, the physician is answerable to the members of the audience if the patient died as a result of an error in his judgment.[1]

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[1] The Chief of Surgery maintains that if a physician is unwilling to admit his mistakes to his colleagues, then the hospital has no place for him.

A few of the presentations are for report purposes. For example, a physician may have attended a particular conference or seminar in another place and be asked to report what happened at that conference. An example of a speech with this purpose occurred after one physician was sent to a series of meetings in Las Vegas to discover the feasibility of an outpatient surgical unit.

For the most part, however, the purpose which the speaker is seeking to achieve is to provide information essential to medical knowledge.

Structure

Each speech can be understood best if viewed as one rhetorical part of the entire conference. That is to say, for example, the case presentation given by the resident frequently would be lacking an introduction or conclusion, and sometimes both, if it were considered apart from the speech which follows. However, as this analysis will reveal, the case presentation fulfills the purposes of an introduction; the responsive speech contains the body of the speech; and the general discussion functions as a conclusion through summaries and directives. The entire conference is given unity by the moderator who frequently makes additional transitions from one phase to the next if the speakers do not do so themselves. Exceptions to this typical conference structure do occur, especially during those times when a guest speaker is asked to speak on a topic not necessarily applicable to a specific hospital case. At these times, the speaker usually structures his speech in the three-part rhetorical form. This analysis, however, focuses on the typical conference speaking.

Case Presentation

The case presentation usually lasts about one-fourth of the entire conference. The time varies somewhat according to the speaker and the complications of the case.

Organizational methods

The organization of the case presentation seems to be fixed in a pattern set by precedent. Basically the presentation's arrangement is topical; some speakers resort to mere listing of the information while other speakers, usually the more experienced or more thoroughly prepared, use this pattern as a guide for presenting a comprehensive discussion of the case. Because of the lack of organizational variety, it is relatively easy to list some of the topics which the speaker considers in preparing his speech and the order in which they are presented. Each speaker, however, presents only those topics which he considers relevant. The following is a schematic presentation of the typical topics considered by most speakers.

A. Chief complaint of the patient on admission
B. History of the present illness
C. Review of symptoms by systems
    1. head, neck
    2. cardio-respiratory
    3. etc.
D. Family history--if relevant
E. Social history--if relevant, e.g., smoking, alcohol intake
F. Past medical history
    1. operations or serious illness
    2. allergies
    3. medicines

G. Physical description (may be graphic and vivid, or general)
    1. vital signs
    2. general condition--those relevant
        a. head, ears, eyes, nose, throat
        b. neck
        c. chest
        d. breast
        e. heart
        f. abdomen
        g. genitalia
        h. rectal
        i. skin
        j. psychological-psychiatric

H. Laboratory findings
    1. blood count
    2. urinalysis
    3. chemistries
    4. EKG--other special tests
    5. X-rays

I. Hospital course

The more thorough speaker usually includes a definition of the problem area and a review of the literature either at the beginning or the end of the presentation, but this does not seem to be considered essential.

The lack of variety in structure is effective in its efficiency and in meeting expectations. For example, the members of the audience listen for the information which they will need in making an assessment of the diagnosis and treatment. They know when to listen for the necessary information. If the speaker has omitted one of the customary topics, he may be asked for that information even if it seemingly is irrelevant, merely because it is missing from its order.

The speaker concludes the case presentation in one of two ways. He most frequently asks for questions which he answers briefly and sits down. In this circumstance, the Chief of Surgery usually offers a transition to the next speaker. The second method is for the speaker to recognize the second speaker in some way which designates him as more authoritative on the theme.

Substantive Speech

The substantive speech is the thematic material of the conference. This portion may be presented by either the resident who presented the case and is now developing the theme, the patient's private physician, or a guest speaker or staff physician. The structure of the presentation sometimes seems to be a matter of speaker status. In all of the speeches, however, the presentation seems to be organized around slides. That is, the picture or chart is shown first, and then the information or material appearing on the slide is explained.

The structure of the resident's speech

The resident who presents the substantive portion of the conference is also the one who has presented the case. He usually is a third or fourth year resident. Even though he is presenting both speeches, he still concludes the introductory case presentation by asking if there are any questions about the case. Unlike one of the popular transitions, these questions are not meant to be rhetorical. He next introduces the substantive speech by a simple brief statement such as "Now I'd like to talk more about cecal volvulus."

The typical speech of the organized resident follows a reflective pattern. An excellent example of this structure was used during the speech concerning cecal volvulus. The first step, a definition of the problem being considered, occurred during the case presentation; the second step, an analysis of the problem, was briefly given at the beginning of the substantive speech because "there is not too much in the literature about this subject." The next step, a consideration of the alternatives, became the possible "types of operations" which should be considered. At this point, however, the speaker decided to postpone this discussion until after the next step, the criteria, was established: "Before I discuss that, you should consider the objectives." The final step in this speech was a brief "summary of what you should do," i.e., the speaker's "solution" for meeting the objectives.

The resident rarely uses any other organizational pattern. Perhaps this can be explained as being the result of utilizing the pattern which is most effective in accomplishing his purpose. That is, the reflective pattern allows the speaker to demonstrate his thorough knowledge of all aspects of the subject. This method of organization also is favorable to this audience whose members frequently hold differing opinions as to the best solution and, for example, may be practicing opposing types of operations. This speaker, thus, considered the alternatives as being acceptable while stating a preference for a particular type of operation.

The structural weakness of many of the speeches given by the resident doctors, however, is the lack of transitions. A common method for moving from point to point seems to be "'O.K.' Click." That is, the speaker concludes the review of the literature by saying "O.K." and then presses the slide projector's remote control apparatus to focus a new picture on the screen. In truth, all of the speakers seem to thrive on the adage that a picture is worth a thousand words.

Organizational methods of private physicians

The private physician usually is the most poorly organized of the speakers in his conference presentations. The reason for this lack probably lies in his view of the conference. For example, many of these are on the teaching staff and feel that their purpose for speaking is merely to give additional information which the resident fails to mention or to answer questions about the case. Thus, this type of speaker seems to be momentarily at a loss immediately after the case presentation and begins with a compliment concerning the previous speech, sometimes saying "Dr. X has left me with little to add." He generally proceeds by reviewing the problem presented by the patient which the resident doctor had discussed and then offers a justification of the treatment of the patient. Although this method could be viewed as a problem-solution structure, the "solution" is presented haphazardly with little regard for any kind of recognizable structure and generally declines into a response to questions with no clearly defined ending.

A favorite means of organizing their material for some of the private physicians, however, is a chronological order. This structure is used primarily to instruct on procedure. That is, the audience learns how to perform a specific type of operation, or what was the best treatment, by being shown in detail, how the patient was treated. It is as if one major point was omitted from the case presentation and was introduced and expanded for the substantive speech. For example, in chronological order, the patient entered the hospital with a complaint, tests were made and the results reported, a diagnosis was made and an operation was performed (but not discussed during the case presentation), the post-operative results are given, and the patient either was dismissed or died. The second speaker, in his substantive speech, then returns to the diagnosis and treatment and elaborates on that topic also in chronological order.

If applicable, the speaker considers the differential diagnosis but the performance of the operation itself is the primary interest, both for the speaker and the audience. An excellent example of this type of well organized speech occurred on March 23, 1974. The subject was hemorrhoids. After the case presentation, the resident proposed that "Dr. X will take over from here; he has some pictures." The chronological order of his main points took the following form:

A. "The first thing is the position of the patient." [He advocated the patient lying on the stomach, a mildly controversial point.]

B. "I like to do a proctoscope. This is usually done in the office but I like to do it again."

C. "Beforehand, I'd like to inject 'x' c·c's of . . . [medication] around the anus."

D. "Now I'm sure you know hemorrhoids usually are in three positions." [The removal of each was shown on slides.]

E. "Now sew up to . . . [a specific point.]"

F. "Now the dressing: Put vaseline gauze on top of anus."

In summary, the private physician seems to see himself in the role of advisor rather than as a speaker. He depends on the pertinent questions being asked as a means of communicating his theories rather than another, more customary, rhetorical pattern. The private physician who also wants to offer instruction in a particular technique or to obtain the acceptance for that technique generally will use a chronological order. Although his purpose may be persuasive, he rarely is overt with that purpose. Again, he relies on means other than organization to achieve that particular objective.

Conference Conclusion

The portion of the conference that usually achieves the purposes of the conclusion of a speech is in the form of questions, answers, and comments by the speakers and audience. This discussion frequently serves as a summary: "After listening to the comments about . . .;" and as a directive: "Are you saying, then, that we should follow the procedure of . . .?" If these purposes are not accomplished by the participant, the Chief of Surgery usually offers a brief summarizing statement and thanks everyone for attending. No formal arrangement is followed other than that precedence seems to be given to doctors having higher status.

Summary of Structure

Other means of categorizing the structure of these speeches might be possible. At times, for example, the case presentation seems to be extended into a major, substantive speech by one doctor while another offers a short response. Another exception is the occasional presentation that has a complete, formal introduction, body, and conclusion. If this speech is the only one that could be considered well organized, then all the others would have to be reevaluated another way. The important criterion of the method that is used, however, is that it seems to meet the expectations of the audience.

Invention

Any critic untrained in medicine and surgery is severely restricted in his attempt to analyze the content of speeches given by physicians to their colleagues. For example, it is impossible to consider the validity of arguments and whether or not the speaker uses all available means in persuading or informing his audience. Ideally, the critic would be well versed in the subject matter and content of the speeches; and although this is possible, it certainly is not likely that any rhetorical critic will be medically trained to the extent a physician is. This is not to say that no analysis of invention should be made. However, the selection of topics can be considered as well as certain principles of the following classical proofs: ethos, or ethical proof; pathos, or emotional proof; and logos, or logical proof.

Selection of subject

The selection of subject matter for the conference speeches is not made arbitrarily by the speaker. This is true not only for the resident doctors but also for the staff physicians and guest lecturers. The academic chief of the department makes the selection based on the following two reasons. First, if a particular case is worthy of further consideration, then it will be the pivot for one of the conferences. Cases are chosen on the basis of their being unique and their potential for an educational experience for the medical audience. Sometimes the uniqueness alone is sufficient for a case to be presented. For example, one patient entered the hospital via the emergency room one Saturday night with a bullet lodged in the back of her throat. According to her surgeon, she should have died during the operation if not before because "it is impossible" to operate and remove an object from that particular location. She survived, however, and her case was presented more as a subject for amazement than as an informative speech on methods for performing such an operation. The particular subject matter, therefore, is the primary reason for the speeches, and the speakers are selected according to their relationship with the case.

Although the subjects of the speeches are not limited to surgical cases, they are related to problems faced by surgeons. Sometimes this relationship is either misunderstood by a guest speaker or he is unwilling to alter his previously prepared speech. One such incident occurred when a physician holding a prominent position in the state rehabilitation program was asked to speak on surgical possibilities for rehabilitation, such as amputation procedures that provide for the prosthetic fittings for amputees.

The speaker began with what he called a "short overview" of the rehabilitation program for the first ten minutes by showing slides of the many public buildings in which they worked and of the Houston Medical Center. The audience, composed of surgeons completely familiar with the facilities, showed its impatience with such a waste of time by quick glances to other members of the audience to see their reactions.

The speaker's next topic for discussion concerned the material used in rehabilitation and his working relationship with engineers to produce the necessary equipment. During the last of the speech, he seemed to realize the inadequacy of his adaptation to the needs of this audience but did not know how to make necessary revisions other than to comment about the need to eliminate some of his material since the allotted time was running out. He related only once to the surgeons, late in the speech, by making an appeal to amputate below the knee when possible in order for the patient to have maximum use of an artificial leg. This relevant point was reviewed during the question and answer period but unfortunately the speech had taken so long that there was little time left for an in depth discussion.

The speaker revealed that he spoke at many "insurance seminars" in an attempt to have rehabilitation covered by insurance policies. The speech would have been relevant to that kind of group and probably had been prepared and used for those seminars. Some adaptation to his present audience could have been made merely by eliminating extraneous slides. However, while other guest speakers obviously use speeches prepared for other audiences, most of their material has been selected for other medical groups and, therefore, is of interest to this particular audience also.

Ethical means

Probably the most effective means the physician uses in gaining acceptance for his ideas is his status as a doctor. The position itself seems to carry an intrinsic ethos even when speaking to colleagues. The speaker establishes an identity with the audience as they share common information by repeatedly beginning statements with "now I'm sure you know," or "you will remember, of course." The primary reason for the effectiveness of ethical proof in the speeches given at the Grand Rounds Conference is that the speaker is assumed to have had experience in treating the illness being discussed. The speaker is chosen because of this experience, and all of the speakers refer frequently to this experience while speaking. In addition to this reason, the ethos of the guest speakers usually is enhanced by their professional reputation that has preceded them and always by the introduction given them by the Chief of Surgery, who usually makes repeated references to the "eminent surgeon."

Emotional means

Emotional proof, or pathos, is less frequently used than other means of appealing to the audience attending these meetings. Most speakers occasionally use emotional involvement at least in the introductory parts of a speech to create interest in the subject, but these physicians almost never employ any type of emotional appeal. The problems presented in the cases themselves provide the means of gaining interest for the speeches which follow. These are presented in precise words and in a manner that is matter-of-fact. Thus what might be extremely pathetic cases have little emotional impact because of the manner in which they are presented. For example, the speaker usually begins abruptly with a statement such as "On May 1, 1973, a twenty-year-old female was admitted to the emergency room with the chief complaint of a severe headache." Sometimes the resident doctor will be more explicit in viewing the case presentation as merely introductory to the next speech: "By way of introduction, I'd like to present a case"; or "The topic of our conversation today is cecal volvulus." However, this objectivity and overt lack of emotion does not evoke any feeling of callousness on the part of the speaker; but rather the speaker and audience, because of their cohesiveness in facing these human frailties, seem to share their unspoken concern, thereby creating no need to dwell on the emotional aspects. Apparently, the speaker assumes that his audience would not be physicians if they were not interested in the welfare of humanity and his responsibility as a speaker is logically and scientifically to impart the most useful information to aid them in performing their duties.

Substantiation and amplification

Most of the speakers follow an established pattern of using various types of support material. For example, definitions occur in only one of two places in a presentation. The speaker will define the illness, problem, or subject either at the very beginning of the case presentation or as the transitory statement between the case and substantive speech. One of the more complete definitions was given as the opening statement for the case presentation in the following manner:

> Our subject today is hemorrhoids. Hemorrhoids is derived from the Greek, meaning bleeding; it also is derived from "piles" meaning "balls." The definition of hemorrhoids is varicosed rectal veins.

Perhaps the use of etymological and historical types of definitions was given as an additional attention device for such a common problem, one which probably needed no definition for this audience's comprehension.

Examples and illustrations are used during the speeches for proof as well as clarification. This form of substantiation usually is in the form of visual material rather than verbal, although both are used. It is difficult to argue with X-ray film or movies. The use of X-rays, of course, is obvious but movies and slides also are shown of many patients. For example, in the speech advocating the use of hyperalimentation, the speaker showed a colored slide of an emaciated man lying on his hospital bed in a comatose condition. The patient appeared quite old and at the point of death. Later, the speaker showed a slide of the same man after six weeks of treatment during which he had gained about thirty pounds. He was standing, alert, and appeared to be the thirty-five year old person that he was. Most of the slides and movies, however, are not that dramatic; they usually are pictures of tumors, intestines, and operations. These visuals replace the "wet clinic," i.e., watching an operation in progress.

Statistical data are an essential means of reporting laboratory findings such as blood pressures, temperatures, and weights; sizes and measurements of tumors, and fistulas; and in ratios and percentages of male and female susceptibilities to, and mortality rates of, certain illnesses. Statistics are used more frequently as reports rather than as proof, except to show the possibility of a causal relationship. For example, in a speech on the syndrome of duodenal obstruction, the higher incidence of its occurring in women than in men was used to indicate that there might be an anatomical relationship; and a new or different type of operation resulting in a lower mortality rate is presented as evidence of the success of the operative treatment.

A common means of documentation is presented as a "review of the literature." Some speakers, however, are haphazard in citing sources for their information, and while the audience might be told that a study in California reporting on a series of one-hundred patients revealed a successful treatment, they might not be told when the study occurred or who reported the study. Frequently the term "the literature" is the only citation for information: "However, everything you can read in the literature reveals that one-third do well; one-third have complications but can be treated medically; and one-third require further surgery after complications. Nevertheless, it is still a good operation." Another frequent method of documentation is by citing only the medical school where a study was made such as "A recent Baylor series revealed . . . ." Occasionally a speaker will give a complete citation of the literature source, i.e., the physician reporting his study, from which hospital, and the journal in which the report can be found. If the audience is to derive full informative value from these speeches, the complete citation would seem to be necessary. No one has ever requested such information either during or immediately after the presentation; and since no written material is given to members of the audience, this information is lost.[2]

In summary, the speakers rely on their own status and experience as surgeons to gain acceptance and appeal for their speeches. This ethical proof seems to meet the expectations of the audience, who probably view it as the major method of substantiation. The speakers use a visual means for optimum proof rather than any historical or literature documentation. Rarely, if ever, do they appeal to an emotional involvement.

Style

Style usually is considered as that feature of language that belongs only to the individual speaker. However, certain characteristics of style are common among the physicians as speakers. The similarities and differences are considered according to the following topics: oral and written style; the point of view of the speaker; concrete, abstract, and metaphorical language and the use of humor.

Oral and written style

The speakers making the case presentation display a combination of oral and written style. First, enough of the information is written and read aloud that it discourages what, in print, would be superfluous reiterations. The listener almost can see the punctuation marks and especially the underlined topics with their stress and the staccato stops and starts. After that first emphasis on imparting information, the speaker's style loosens somewhat into phrases and searching for words accompanied by vocalized pauses. For some reason, most of the doctors interviewed see the problem of using "uh" as a major problem in their speaking. One prominent Houston heart surgeon told of taking his daughter to hear him speak and afterward he asked her about his success. She replied that she had counted fourteen "uhs!" However, this form of vocalized pauses is not used to such a distracting degree that the physicians seem to think. As the speaker gains confidence, he moves away from a formal written style into being casual and informal. Sometimes the private physician becomes so nonchalant that his style, like his delivery, belies the importance of his words. An example of this is his overuse of euphemisms, which is discussed under metaphorical language. Fortunately, however, as he acquires a higher professional status, he develops a formal but conversational manner, a natural and easy style.

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[2] The Grand Rounds Conferences in services other than surgery use mimeographed material for distribution during the sessions.

Point of view

One of the most interesting stylistic characteristics in the speaking of physicians is the use of the plural first person by the speaker. He rarely speaks in the singular first person in describing his activities. For example, he might say, "We learned a lot from this case,"; "We tried the following treatment," or "Mrs. Smith asked us which would be wise," but avoids statements such as "I operated on Mr. Jones." This characteristic is held not only by the resident, but also by the private physicians both those on the hospital staff and those who are guest speakers. The most plausible reason for this plurality is the team concept surrounding patient care in a large hospital. In a teaching hospital the patient is seen and treated by his private physician, several resident doctors, perhaps an intern or two, various technicians, and a group of nursing staff. This point of view was illustrated by the Chief of Surgery during hospital rounds as he introduced "the members of my team" to his patients. Although the physician uses "we" in talking to his patients in the hospital, he changes to first person singular when he sees a patient in his office. That he feels the need to use the royal "we" in speaking to his colleagues could imply his reluctance to assume full responsibility for his actions; it could be an attempt to project objectivity or even thoroughness ("We all agree, it is not just my idea."); it might be an attempt at audience involvement; or it might merely be a habit perpetuated by hearing other doctors.

Many of the physicians also use the second person possessive pronoun instead of limiting adjectives or articles such as "the" and "a." For example, he might say "Your patient will demonstrate the following symptoms." This use often is related to directives being offered, but it serves to place them on a more personal basis.

Concrete, abstract and metaphorical language

A paradox seems to exist in the physician's use of concrete, abstract, and metaphorical language. Literal language usually is associated with science, while figurative belongs to literature. This distinction certainly is not valid in the speeches of these scientists-physicians. Recall that the case presentation includes laboratory and X-ray reports as well as a physical description of the patient and his symptoms. The speaker frequently will use concrete descriptions at one point such as "the body temperature was 39° C." while changing to a more vivid "the skin was real hot and burning to the touch" at another time. Colors are some of the most commonly used descriptive adjectives but frequently they do not stand alone. They become "dark bilious green," or "bright canary yellow," and even "ketchupy in color and consistency."

The greatest degree of specificity of language is in percentages and in the descriptions giving location and size. That is, the mortality rate of a particular illness always is given: "Forty-five percent of all patients in the series of one-hundred cases died"; and a tumor is discussed according to its exact location and size in millimeters. For the most part, however, a lay critic is impressed by the inexactness of this science.

Abbreviations.--A stylistic characteristic that may be unique only in that each profession probably has its own is the use of abbreviations. The medical profession seems to have a profusion constantly in use. Some of the most commonly used include DOA (dead on arrival), D and C (dilation and curettage of the uterus), and OB and Gyn (obstetrics and gynecology), BMR (basal metabolism rate), and EKG or ECG (electrocardiogram); but when the surgeon mentions an LP, he is not talking about a long-playing phonograph record, but a lumbar puncture, or spinal tap, and upper and lower GI series have nothing to do with the government or military, but with X-ray films of the upper or lower gastrointestinal tract. The abbreviations become so common in speaking with colleagues that doctors sometimes fail to clarify when speaking to others. Probably the explanation for these abbreviations is their efficiency, i.e., abbreviations take minute space on charts and hospital records. Sometimes, however, the use of abbreviations seem to be a means of impressing the listener with medical jargon.

Ethical language.--Some traits observed in the physician's speaking with his colleagues are being termed ethical language because they seem to be a result of medical ethics. The first of these is a failure to name hospitals where the speaker felt a patient did not receive adequate care. For example, sometimes a person is dissatisfied with the treatment he received as a patient of a physician at one hospital and subsequently enters St. Joseph Hospital under the care of a doctor on its staff. In speaking about the medical history of that patient, the surgeon uses terms such as "the patient had been in another hospital twice before coming to St. Joseph," and when the speaker is particularly incensed over the previous treatment he tends to emphasize "that institution across town" in a sarcastic or derogatory manner. In addition to his failure to designate specifically certain hospitals, the speaker avoids naming the other physician of whom he disapproves.

The second type of ethical language that the physician exhibits is the use of names to designate patients. Contrary to popular belief and numerous jokes, the physician rarely, if ever, speaks about "the gall bladder in room 522" even when speaking with his colleagues. In fact, it is amazing how long the physician remembers the name of a particular patient. He is apt to recall "Mr. Abernathy, who was a patient here, oh back about ten or fifteen years ago--weren't you in on that case, Joe?" and the second doctor may respond, "Sure, wasn't he the one who had the amputation?" Ironically, however, the doctors do talk about the "ownership of patients," not merely as "my patient" or "your patient" but, in heated disagreements over whom should be called in an emergency they claim "he doesn't belong to you, he is mine."

Euphemisms.--One of the most fascinating stylistic traits of these physicians is their use of euphemisms for "death." Of all professional groups, this one obviously must face death more frequently than any other. Yet these speakers avoid the specificity of words such as die, died, dying, death, and dead. Substitutions range from the more formal "mortality rate," to the commonly used "passed on," and the amusing, such as "bought the farm," and once a patient's "condition was so bad that the vultures were hovering over the hospital." The physicians seem to be unaware of their euphemistic language. When asked the reason for their avoidance of the word death, one surgeon laughingly replied that it was because his patients never died! The fact that euphemisms are not practiced for other words or actions might indicate an unwillingness to admit failure in curing a patient or in solving the problem. The euphemisms also might be an attempt to appear objective rather than to demonstrate an emotional involvement with the patients.

Humor.--Another means by which the speakers seem to lessen the burden of personal involvement is through the use of humor. They smile at both themselves and their patients; to laugh would be too raucous a description of their levity. Although many amusing anecdotes are told about patients, particularly disgruntled ones, the levity never approaches ridicule. The use of humor is found more frequently in the speeches of the private physicians than in those of the residents, who generally are more serious. However, one-fourth year resident began a presentation by referring to himself as an "expert" on a particular illness since "I have been associated with one case." Humor is a tenuous aspect of speech and loses much out of context but the speaker and audience in these conferences derive a great deal from its subleties.

Delivery

The importance of good delivery seems almost to be self-evident. Cicero considered it to be significant for a good orator and experimental studies tend to support that theory. The consensus of most research indicates that the characteristics of good delivery include such attributes as flexibility, animation, and directness.[3] The success and failures in achieving these qualities by physicians is discussed according to their modes of delivery general appearance, bodily action, and vocal characteristics.

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[3] Wayne N. Thompson, Quantitative Research in Public Address and Communication (New York: Random House, 1967), pp. 82-86.

Mode of delivery

Basically, all of the speeches should be considered extemporaneous in that the extraordinary amount of time spent in medical training accounts for the greatest percentage of preparation for the presentations. However, the case presentation usually is delivered with a manuscript. The more inexperienced the doctor, the more apt he is to rely heavily upon his notes. In fact, many of the younger residents resort to reading aloud the data concerning the case as well as their review of the literature. Most, however, also include some explanatory comments as an aside.

While the resident utilizes his own handwritten manuscript, both he and the private physician utilize another, more unique, "manuscript" for the substantive speech. Rarely do the private doctors and guest speakers use a typical manuscript. Instead they rely entirely on topical outlines that are either in the form of slides for the projection machine or a typed outline for the opaque projector. Thus the audience sees each "topic" while the speaker reads and amplifies that material.

General appearance

If one word had to be selected to describe the general appearance of physicians as speakers, that word would be conservative. It is probable that the profession itself perpetuates such an appearance. A deviation from conservatism, if it can be called a deviation, is an occasional turtle neck sweater with a sport coat instead of the usual blue or brown business suit worn by the men, or the very short skirts worn by the young female residents. Hair styles of the men are cut above the ears and none show hair below the collar. While mustaches are seen on the medical students and a few residents, no one wears a beard.

The private physician's more expensive suit is occasionally substituted with a hospital white coat. When he is speaking, however, he wears his business suit. The resident will occasionally speak while wearing his surgical "greens,"[4] which is suggestive of his extremely busy schedule, i.e., he did not have time to change.

Another characteristic common to all of these physicians is their attractiveness. Perhaps this attribute is merely coincidental but where are the "ugly" doctors? The younger ones display an "all-American, boy-next-door look" while the older doctors have a "leading man" appearance or else a "fatherly" image. Although this general attractiveness may have little value when they are speaking to their colleagues, it surely has some influence in the doctor-patient relationship. The following story was told by a sixty-year-old patient of one of the young surgeons when she was interviewed about the communication between her and the doctor. She replied that she never remembered what he told her, so she always brought someone with her to listen. The reason, however, was not because he used medical terminology or that he was in a hurry, but rather because he was so good-looking that she could not keep her mind on what he was saying! After the last visit, she said that she had asked her companion to review what the doctor had told her, but unfortunately she too had been "too taken" with his looks to listen.

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[4] White coats with the doctor's name over the breast pocket usually are worn in the hospital but the green cotton pants and shirts are used in surgery. Such "costumes" probably carry their own symbols of status.

Bodily action

One of the most distracting features of the doctor's delivery is his bodily action: the tense posture and pacing; poor handling of notes and visual aids; uncoordinated or habitual gestures; and a frequent back-to-the-audience stance. The surgeon who is at ease beside the operating table seems to suffer from the same stage fright as the freshman in a speech class.

The resident, perhaps because he is usually accompanied by a manuscript, stands behind the podium, which includes a small speaker light. Here he assumes one or all of the following characteristics, usually in a progressive order: a rigid stance with hands gripping notes or the stand; a repeated shifting of weight from one foot to the other; sometimes suddenly leaning on the podium, possibly to indicate casualness; and an abrupt movement to the projection screen or X-ray display to illustrate a point, where he finishes his speech with his back to the audience. Exceptions, of course, do exist. One notable exception was a presentation by a third year female resident who had a formal but relaxed manner. She was the first to record her notes on index cards instead of yellow legal sheets or white typing paper. She held these notes in her hand as she moved from behind the podium to a position where she could see both the audience and the screen.

The private physician, while obviously more relaxed than the younger doctors, uses such an informal mode of delivery that he frequently obstructs his own presentation. That is, he walks around as he talks to the extent that he is not always in the best position to have the attention of the entire audience.

The constant use of visual aids presents a greater problem for the younger doctors than for the more experienced ones. The resident doctor has difficulty pinpointing information or gaining attention for a specific area being seen on the screen or an X-ray. The use of a pointer would eliminate this problem while allowing the speaker to maintain eye contact with the audience.

The guest speaker commands the best use of delivery in effecting his purposes. He is direct, yet informal, with but few superfluous gestures. His movements enhance and emphasize specific illustrations and ideas. Visual aids never seem to present a problem to him even though he is not always familiar with the physical setting. It might be supposed that his greater experience in speaking accounts for his greater ease; or, it might be that his ethos as an invited speaker gives him the confidence to deliver his speech in the most effective manner. However, the casual relationship might be reversed. One doctor observed that not many people see a surgeon operate; his reputation, therefore, frequently is dependent on his speaking ability. Thus, the question might be, does the surgeon's more interesting speeches gain him a reputation which affords him an opportunity to give even more speeches, thereby further enhancing his reputation?

Vocal characteristics

The vocal tones of the surgeons are those usually admired. The men have mellow, resonant voices that are pleasing and easily heard. A few have slightly nasal qualities but not to a distracting extent. The women also have a deeper timbre than sometimes is attributed to female voices. C. David Mortensen offers an interesting summary of research in paralanguage, i.e., how the human voice functions nonverbally, in which he mentions that people judge the vocal qualities of certain professions purely on the basis of a stereotype of what they thought a person in that profession should sound like.[5] The stereotype becomes relevant in determining their expectations and actual perceptions. Without experimentally determining if the doctors in this study display the stereotyped qualities for physicians, the assumption is that such pleasingly resonant tones would fit such a category.

The vocal distinctions among the doctors lie in the slight accents resulting from the nationalities represented. While some of the foreign-born surgeons admit to speaking English for only four to eight years, they are remarkably free from language problems. Only one speaks with such an accent that comprehension is difficult. Superficially these various accents should pose little problem in communicating with colleagues, but because of the poor reputation of some foreign medical schools, doctors training in those schools may have to overcome some prejudices of their American peers.

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[5] Communication: The Study of Human Interaction (New York: McGraw-Hill Book Company, 1972), p. 228.

The monotonous delivery of some of the younger doctors seems to result from either nervousness or an erroneous conception of what informative speaking should sound like. Perhaps a lack of variation in pitch and rate indicates the dullness of acquiring or imparting information. Fortunately these characteristics seem to change with experience and criticism, and the fourth year resident acquires a more conversational manner than he had previously.

Summary

The physicians become skilled in speaking as their status and confidence increase but the potential for good delivery is obvious in even the most inexperienced doctor. The major problem, if it can be called that, originates in the cultural realm. Mortensen observes that matters pertaining to gesture, voice, and posture are culturally determined.[6] For example, the proximity of speaker to audience and his eye contact with members of that audience may reflect a culturally defined pattern of behavior. Such might be the case of an American who stands further away from his listener than his Latin American counterpart, who would see the intervening distance as an indication of coldness. For some, the lowering of eyes rather than direct eye contact is a sign of respect. Because of the variety of meanings which may be attached to the qualities of delivery, the foreign-trained physicians may have problems in communicating with the predominately American, White, Anglo-Saxon audience.

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[6] *Ibid.*, pp. 350-51.

PART II. SPEAKING WITH PATIENTS

INTRODUCTION

Communication at its most effective level is fraught with problems; but under some circumstances its success seems almost impossible. Such seems the case when a physician is speaking with his patients. The situation frequently is full of emotional blocks: the patient may be facing possible pain, disability, or even death, as he listens to the physician. If the doctor thinks that communication with his patient is important, then he must overcome these problems.

In the fourth chapter are the results of a survey taken to determine how the surgeons participating in the study initially were selected by their patients. During the interviews with the patients, they indicated the reasons for their continuing satisfaction with their doctors and the sources of theirdissatisfaction with him.

The surgeon's philosophy concerning his responsibility for communication and the importance of patients' comprehension is compared with the patient's attitude toward these same ideas in the fifth chapter. Included in this section is a discussion of three controversial problems in physicians' communication: should the terminal patient be told about his life expectancy; how much should a patient be told before he gives his "informed consent" to an operation; and should a patient be told of a disagreement between consulting doctors concerning his treatment.

The sixth chapter analyzes the patients' desire and need for information according to the following topics: the patients' satisfaction with the information; the kind of information he wants; his comprehension; and the possible passivity of patients in asking for information.

Chapter Seven concerns the image of the physician as a communicator. This chapter includes both the physician's and his patient's view of his accessibility for discussions; his use of medical language in talking with his patients; and the development of a personal relationship as a means of reducing rhetorical distance.

Methodology and Background

The primary source of the information used in analyzing communication between physicians and patients are the data obtained (1) through structure interviews with the patients of the surgeons cooperating with this study and (2) through interviews and a questionnaire completed by the surgeons. The questions asked of patients appear in Appendix A, and those asked of the physicians appear in Appendix B. The procedures for obtaining the data from these two groups differ and are explained in detail.

Physicians

Of the group of surgeons participating in the Grand Rounds Conference discussed in Part I, sixteen cooperated for the portion of the study involving communication with patients. Although discussions, conversations, and interviews were held with many of these doctors both at the hospital and in their offices during the ten month study, the data presented in Part II are only that obtained directly from the answers on the questionnaire unless otherwise indicated.

At the conclusion of one of the Saturday conferences, the Chief of Surgery asked those who would agree to participate to remain and answer the questions for the survey.

The surgeons were given no directions other than those which appeared on the questionnaire. The number of doctors checking a given possible response appears next to that response in Appendix B. Some of the questions evoked a general discussion after the completion of the questionnaire and thses comments are included in the analysis.

The length of time the surgeons have been M.D.'s varied from one year to over twenty years. This span was divided into four groups to determine if any correlation existed between the number of years the respondent had practiced medicine and any specific response, but no pattern emerged. The number of physicians of differing ethnic, cultural, or racial backgrounds was too small to analyze for relationships in their responses.

Patients

The total number of patients interviewed was eighty-eight. The ages ranged from seventeen to seventy-five. More female patients (sixty) were interviewed than male patients (twenty-eight). According to the surgeons, however, these statistics illustrate the usual ratio of the sexes as surgical patients.

Thirty percent of the total number of patients are Mexican-American, forty-five percent are Anglo-American, and nineteen percent are Black-American. The race of the remaining six percent accidentally was not recorded. Because such a large percentage (at least forty-seven percent) of the clinic patients are Spanish speaking, only bilingual nursing and staff personnel are hired. This is not to say that these patients speak only Spanish, only that a few cannot speak English sufficiently well to be understood.

Two of the private patients visiting their doctor's office on the days of the interviews did not participate: one refused and one left when the office nurse failed to direct her into the room with the interviewer. Once the patient had been interviewed, he was not seen by the interviewer on subsequent visits. Because both clinic and private patients were used in the study, their responses are discussed separately when a difference might be relevant.

At the beginning of each interview, the patients was told the purpose of the study and reassured that there was no way that either the doctors or the nurses could discover which patient was responsible for the answers. Although the possible answers appear to be limited to those appearing on the questionnaire, some of the questions in the actual interview were open-ended and the responses placed in appropriate categories. The patients were encouraged to comment freely.

Clinic patients.--The Sister in charge of the outpatients clinic suggested that her office be used for the interviews.

After each patient left the examining room where he had been seen by a doctor, he was brought to this office by a nurse who usually explained that there was a lady who would like to talk to him. Once when a patient complained to the nurse prior to seeing the doctor, she suggested that he "be sure to tell that" when he was interviewed. However, he did not mention the complaint. The door to the corridor was closed during interviews so that the doctors were unaware when the interviews occurred.

All but two of the same questions were used for both private and clinic patients. The latter were not asked their occupation and the selection of the doctor. The first question was excluded after the first two interviews when it was realized that such a question might be misconstrued as having to do with the amount of the fee being charged for the clinic. That is, a patient is charged according to his ability to pay and his occupation possibly influences this fee.

The second question was excluded because the clinic patient has no control over the selection of the doctor he sees. The clinic has specific days designated for the various services, i.e., one day for surgical patients, another for obstetrics and gynecology. Hence the residents of the particular service are on duty for that day. The chief resident is in charge of the clinic. He looks at the charts of all the patients for that day and assigns each patient to a specific doctor. Some chiefs base their decision on who treated the patient on a previous visit; others seem to use a random assignment. Thus the patient is never certain which doctor he will see. An additional difficulty in establishing any rapport between doctor and patient is that some residents will rotate between affiliated hospitals, thereby being absent from this clinic for several months; and of course they leave for private practive at the conclusion of their four-year residency. A long time patient and a patient who has had complications after surgery are apt to have a change of doctors during their treatment period.

Private patients.--The procedure for interviewing the private patients differed only slightly. One surgeon preferred that his patients be interviewed prior to his seeing them. He felt that to do otherwise might hinder the patients, i.e., they would not mind answering questions while they were waiting to see him but might resent a prolonging of their stay in the doctor's office. The usual procedure, however, was for the patient to be interviewed immediately after seeing the doctor.

Possible problems might be associated with either of the procedures. For example, a "recency" or "halo" effect might occur when the patient is interviewed immediately after seeing the doctor. That is, the doctor's anticipation of the patient's interview might influence his communication and the patient, being the recipient of better communication, recalls only the doctor's most recent effort. On the other hand, when the patient is interviewed prior to seeing the doctor, he might be unwilling to criticize someone upon whom he is dependent for his health. This possibility probably is greater if the patient is suffering or worried about his condition.

One surgeon made an observation that might be an influencing factor on the doctor-patient communication. He stated that each physician "trains" his patients. For example, they learn by his expressions of approval or disapproval whether or not to telephone for information and the length of time he is willing to devote to discussions. The patients themselves may never be aware of this influence, but nevertheless accept and are satisfied with the resulting communication.

CHAPTER FOUR

PATIENT EXPECTATIONS

The importance of the physicians' being effective in communicating with his patients cannot be over emphasized. Realistically his livelihood depends upon how successful he is in fulfilling the expectations of his patients. He is in essence a self-employed businessman who is selling his services to a specific clientele. Unlike the businessman, however, he cannot advertise to build his reputation but has to rely on word-of-mouth. Actually, most patients usually are in no position to know whether a doctor is "good" or not; they know whether or not they feel better after treatment, but they do not know how much better they might have felt if they had gone to another physician. However, the human body is not always either sick or well; how a person feels is not necessarily an indication of the state of his health. Because many people realize these limitations, they are concerned about their initial selection of a physician; then, they substitute expectations other than their own state of feeling as criteria for retaining the services of a particular physician.

Initial selection of a doctor

How a prospective patient selects his physician is an interesting problem. However, because the physicians participating in this study are surgeons, the answers from their private patients to a question concerning their selection are not surprising. In seventy percent of the cases, the surgeon had been selected by another physician, usually a general practitioner or internist. Many times the referral was based on the surgeon's specialty. That is, his practice may focus on one organ or illness more than another, e.g., the heart, the rectum, or cancer. The large number of referrals lends credence to the wisdom of building a reputation with one's colleagues. Of the remaining patients, all but one responded that either a friend or an employer had recommended the doctor; the exception was an emergency case who initially saw the surgeon on call at the hospital.

The clinic patients, of course, have no choice other than that which they make in coming to the outpatient clinic. The chief resident assigns the patient to a doctor. The surgeon performing the operation usually is in charge of the follow-up treatment during convalesence. Since the resident is not on the permanent clinic staff, however, he may not be able to continue indefinitely as the patient's doctor.

Although the clinic patient sometimes may develop a prejudice for or against a specific doctor, he rarely makes this known. In fact, many of these patients are not certain who "their" doctor is. This question led to an amusing repercussion of this study. On visits subsequent to the interview, the patients began asking the names of the doctors, and even requested the nurses to write the name down, so they would know it if they were ever asked again.

Retention of a doctor's services

A characteristic that probably is unique to specialists is the length of time that the patient considers the physician to be "his" doctor. Frequently the patient prefaces his remarks with statements such as "He isn't my doctor, he's just a surgeon," or "My doctor sent me to see him." For a group who sometimes considers itself the elite of health care, these responses may sound deprecatory.

The interviews revealed that over ninety-nine percent of the patients had been under the care of their surgeons for less than five years; and fifty percent had been under their care less than one year. These percentages were true for both private and clinic patients. A case might be made for providing an explanation according to the mobility of the people in a metropolitan area, but a better analysis is linked to the type of medical care with which surgery is concerned. That is, the patient has a specific problem, he sees a surgeon, he has an operation, he recovers or dies, and he does not return. The exceptions occur when the same patient has complications or another surgical problem and, if he were satisfied with his previous surgeon, he returns to that doctor. This is not to say that surgeons are concerned only with problems which can be solved by an operation; frequently they function much as a general practitioner if the patient desires to continue with their services. Nevertheless, a doctor usually has his surgical patients for a relatively brief span of time; but the problem is still one of meeting the expectations of his patients.

Sources of dissatisfaction

Why does a patient become dissatisfied with his doctor? Patients were asked three questions in an effort to determine the sources of their dissatisfaction with doctors. The first was "Would you recommend your previous doctor to a friend? That is, if you had a friend who needed a doctor, would you recommend the one who had been treating you?" If the answer was "no," the second question was "Can you give me some reasons why you wouldn't?" These questions were asked about the patient's previous rather than his present doctor to allow for more honest criticism if the patient felt any reluctance to discuss the doctor currently treating him. Nevertheless, it served as an opener and allayed any initial suspicion. For example, the patient might answer "The other doctor charged too much but this one doesn't do that." After receiving some positive feedback or a noncommittal response, he might continue, "This one's rates are O.K. but you sure do have to wait a long time to ever get in to see him."

The patient was allowed a wide latitude in his answers but if he gave any indication that he either had no criticism or was having trouble voicing any, he was asked to respond to specific items such as "Well, would you say he was a good doctor?" At the end of the conversation, the patient was asked to offer any suggestion by which his current doctor could improve. The comments from all three of these questions were grouped into categories not mutually exclusive but serving to indicate unfulfilled expectations of the patients.

Diagnosis and treatment.--Ironically, of the thirty-one patients who expressed some kind of dissatisfaction with the doctor, only seven mentioned diagnosis or medical treatment as a source of their discontent. One of these was concerned that the doctor did not give him the medicine he asked for, i.e., he had a cold and wanted a penicillin injection but the doctor gave him a prescription for something else. Another was upset because she had been to two doctors and received a different diagnosis from each one. Other comments included the physician was "not a good doctor because he was no good as a person" and the "treatment was unsuccessful."

The low percentage of patients expressing dissatisfaction with their medical treatment is readily understood if the patient were commenting only about his present doctor. That is, he would no longer be his patient if he did not consider the physician to be a "good doctor." But this explanation would not account for the fact that many of these patients were talking about previous doctors as well. One assumption, therefore, is that a patient is reluctant to criticize a physician's method of treatment because the doctor still holds that certain aura attributed to his superior knowledge. The patient might be dissatisfied with the outcome of the treatment but be uncertain if it is a result of the failure of his doctor or merely another example of his own frailty.

Time.--The largest number of complaints concerned time spent in waiting and the doctor's busy schedule. This category obviously overlaps the others. Six patients were "tired of waiting for doctors"; four felt that doctors were "too busy"; one wanted the doctor to try to "meet his schedules"; and another four advised that the doctor should take more time with his patients. Some of the patients, however, offered excuses for the doctors at the same time they were criticizing them for not keeping appointments. They mentioned emergencies and problems at the hospital, but some of them felt that the main problem was that the doctor over scheduled his appointments. That is, he did not allow adequate time for each patient.

Supplementary information that developed from the study indicates that the nurses are more upset than the patient over the doctor's failure to be prompt. The reason for this paradox is that while the patient attributes the doctor's being late for appointments to an emergency, the nurse is in a better position to know other, less acceptable explanations. The clinic nurses become indignant on the patient's behalf, knowing that the doctor forgets that these patients have more problems than private physicians' patients in being absent from work, having to pay babysitters, and meeting bus schedules that are their only means of transporation. Thus the clinic nurse sees the physician as being unconcerned with this type of patient. The office nurse or receptionist also is irritated when the doctor fails to remain on the schedule because she feels the need to offer explanations to the patients as they wait in the office.

Unconcern.--Only three patients voiced dissatisfaction over the physician's lack of concern. The unconcern toward the patient was an isolated example in one case: "The doctor acted as if he didn't want to touch me." The other two were more general: He is not interested in his patients and he has a poor attitude. The fact that such a few saw unconcern as a problem does not indicate necessarily that this is an unimportant criticism. Actually the opposite is true. The patients are more willing to wait hours for a doctor than they are willing to see one who appears unconcerned about them as a person. Showing concern is a primary characteristic of a "good doctor" according to most patients.

Communication.--Specific questions about the ability and willingness of the doctors to communicate were asked during the structured interview and are discussed in more detail during subsequent chapters. However, five of the patients voicing dissatisfaction with their previous or present doctors specifically mentioned the failure to communicate as a source for their discontent. The most frequent comment, in essence, was that the doctor should explain in more detail. One younger patient felt that the physician did not bother to talk much to young patients.

Related to ineffective communication are some comments previously categorized as problems in treatment and lack of concern. For example, one of the criticisms in the physician's diagnosis was that "the doctor needs to know more about his patients." What the person seemed to be saying was that the more a doctor knows about a person's problems, life, and symptoms, the more accurate would be his diagnosis. Most of the doctors seem to agree with this judgment but their busy schedule often interferes. Thus all of these categories interact to an extent that isolation of one variable becomes impossible.

Miscellaneous.--Some of the various other sources of dissatisfaction with the physician include the following: the patient did not like the office but did not clarify whether it was the location, the staff, or another reason for this dislike; one patient, a former nurse, knew one physician to be "a woman chaser"; and one patient was incensed about the doctor's charging too much for a specific operation because "the insurance company said it was too much and wouldn't pay the bill." It is impossible, of course, for the physician to achieve perfection but more effective communication might have eliminated some of these sources of dissatisfaction.

Sources of satisfaction

The great majority of patients were satisfied with their physician; they consider him to be a "good doctor." When asked for any further criticism or any suggestions as to how the doctor could improve, they usually replied "none." Many of these amplified this answer by explaining why they felt there was "no room for improvement." These unsolicited comments provide insight into those qualities of a doctor the patient holds in high esteem.

Bedside manner.--The traits normally associated with a good bedside manner were mentioned frequently. These characteristics included being patient, calm, reassuring, friendly, and courteous. One patient stated clearly that she liked his "bedside manner," while another one, a clinic patient, expressed her gratitude that the doctors treated her "like royalty." Most considered that the doctor was "concerned" about them and their families. Two patients especially were appreciative of the extra time their doctors took to talk to a member of their family. In one case the doctor himself made a long distance telephone call to the daughter of his patient instead of asking the nurse to make the call as had been requested. The other patient had been concerned over the long wait in the operating room and was pleased that the surgeon himself went to the waiting room to tell her husband that he had not begun the operation. These examples illustrate how a doctor communicates his interest and concern for his patients and thereby wins the extreme gratitude of the patients and their families.

Effective communication.--Patients specifically cited effective communication as the traits they attributed to their "perfect" doctor equally as often as they had mentioned the qualities of a good bedside manner. That effective communication may be a part of a good bedside manner probably is true, but for the purposes here, it is considered separately. The most frequently mentioned traits were truthfulness, honesty, and frankness in communication--probably all expressions of the same characteristic.

Time.--The doctor's busy schedule again occasionally was mentioned in connection with the characteristics of a good doctor.

In these cases, however, the patient praised the physician's promptness and willingness to take sufficient time for each patient. One person commented that the surgeon "doesn't rush you out after using big words."

Diagnosis and treatment.--Ironically, the patients rarely mentioned characteristics concerned with the doctor's diagnosis and treatment as being traits of a "good doctor." Only three times were comments offered which might fit this category: "The doctor did me good"; "He doesn't hurt"; and "The doctor is gentle."

Analysis and summary

The initial selection of the surgeon is made most frequently on the basis of recommendations, usually by another physician. These referrals are related to the medical qualifications of the surgeon. Thus the surgeon's professional reputation, enhanced through his publications and speaking ability, gains him the substantial percentage of his private practice.

He has acquired the remaining percentage of his patients through the recommendations of their friends, relatives, or employers, i.e., word of mouth advertising. Therefore, he acquires some patients and retains the others according to how well he meets the expectations of those patients.

Certain traits of the physician have emerged as sources of satisfaction and sources of dissatisfaction to the patient. Although these characteristics are not mutually exclusive, they indicate a profile of a doctor who achieves the expectations of his patients.

After the initial selection is made, the patient seems to assume that the surgeon is medically qualified and thus rarely uses his diagnosis and treatment as criteria for retaining him as his physician. A good bedside manner and effective communication ranked equally high as sources of satisfaction for the patient. These two categories probably are interrelated to the extent that successful communication and willingness to communicate are a means of creating the highly esteemed bedside manner.

Being prompt in meeting appointments seems to be a desirable trait. Keeping patients waiting for long periods of time constituted the single most often voiced source of dissatisfaction; this is not to say, however, that it is the most important, or even a crucial, trait. While patients complain most often about having to wait for the doctor, they remain his patients; they expect to have to wait for such a busy doctor who frequently has emergencies that demand priority. They offer excuses for him while expressing irritation over this trait. On the other hand, being prompt was rarely mentioned as a characteristic of the "perfect doctor." His erratic arrivals and departures probably are a nonverbal means of communicating his importance, thereby meeting the prior expectations of his patients.

Thus the doctor who is most highly esteemed seems to be the one who is friendly, reassuring, takes an interest in all of the patient's problems, and shows a real concern for everyone. One person's description of his surgeon seems to summarize many of these qualities: "He hates to see you flinch." How the surgeon uses some of these desirable qualities is discussed in Chapter Seven.

CHAPTER FIVE

PHILOSOPHY OF THE PHYSICIAN CONCERNING COMMUNICATION WITH HIS PATIENTS

The attitude of the physician toward his responsibility in communicating with his patients is important in determining his success or failure in that communication. In effect, how much or how little does he believe that patients should know about medical treatment and who is responsible for imparting that information? Included in this chapter are discussions of who is responsible for educating patients and potential patients and the attitude of the surgeon concerning the importance of patients' comprehension. This section also considers three controversial problems with which the surgeon is faced: how much should the terminally ill be told and who holds that responsibility; according to the surgeon, how important is complete understanding to signing an "informed consent" for surgery; and should a patient be told of a difference in opinion between consulting physicians? The analysis includes the surgeon's view of his success and effectiveness in communication.

Responsibility for Educating the Public

The surgeons were asked "To whom belongs the responsibility of educating the public concerning medical research and its findings?" An overwhelming majority stated that this responsibility belongs to "all doctors." In fact, only one surgeon felt that "there is no need to educate the public in these matters," and one considered the responsibility to belong to journalists. No one thought the American Medical Association had this obligation. Thus it can be assumed that the surgeons accept the general responsibility of informing the public.

Source of patients' information

The above assumption, however, is not altogether supported by the surgeons' responses to this question: "In your opinion, from which of the following sources do most people receive most of their information concerning illnesses and their treatment?" The possible answers included "their doctor, nurses, newspaper, friends or family, and television programs." Less than half of the physicians thought that people receive most of their medical knowledge from their doctors, while forty percent thought they received it from friends and families. The remaining numbers were equally divided between "newspapers and magazines" and "television programs," while "nurses" were not thought to be a source of information at all. The results seem to indicate that their belief that while all doctors are responsible for educating the public, that public must gain the information indirectly from friends and family.

The results were different, however, when the questions were more specifically about "patients" rather than "most people." This question was phrased in the following manner: "From whom do patients obtain most of their information about their condition, treatment, and progress?" With only one exception, each surgeon responded that the patient obtained the information from his physician. Some of the doctors emphasized that this was true if the physician were himself. That is, each surgeon indicated quite clearly that he was explaining everything to his patients.

Seventy-five of the patients agreed that most of the information concerning their illness and treatment was obtained from their doctor. However, another thirteen responded that the nurse gave them such information and only one mentioned his family as a source. It should be noted that these fourteen who disagreed with the viewpoint of the physicians are all clinic patients. These patients, because of the nature of the clinic, probably rely on the nurses (of whom all speak Spanish) to provide a feeling of continuity of service since this personnel is not subject to as much change as the clinic doctors. Thus the clinic nurses play a larger role in medical communication than their counterpart in the private offices.

Importance of Comprehension

The surgeons were asked to assess the necessity of a patient's comprehending his diagnosis in a further attempt to determine their attitude toward the importance of communicating this information to the patient. Almost thirty percent felt that the patient's comprehension of the diagnosis was "helpful but not essential." The remaining doctors considered it to be essential. No one considered that it was a hindrance or unnecessary; at least no one admitted it to the interviewer whom they know to be associated with the field of oral communication.

These results probably indicate the reason for their optimism in estimating the percentage of patients who usually understand the diagnosis and treatment of their illnesses. Only one doctor considered that less than five percent of patients comprehended this information, while two other doctors placed the figure at less than one-fourth. Thirteen estimated over half of their patients understood the diagnosis and treatment; and three of these stated that between ninety-six and ninety-nine percent comprehended.

In an effort to obtain an example of the surgeon's willingness to communicate what he considers to be at least helpful, if not always essential, information, the following question was posed: "_After_ an operation, to whom do you explain the results in detail?" Most of the respondents gave more than one answer, the most frequent being "the patient, as soon as he is capable of understanding." Another popular response was "relatives and friends who are present," while only five surgeons answered "one family member only." An attempt was made to verify these responses but because of the possible influence of an observer, the results were felt to be invalid. That is, several surgeons were observed during hospital visits with their patients. The observer was introduced as "a member of our team" to the patients, but all of the doctors were aware of the purpose of the observation.

Questions also were asked involving three problems that seemingly have no perfect solution. All are concerned with the importance placed on communicating specific kinds of information: (1) Should the terminally ill be told the truth and who should tell him? (2) Should a patient comprehend fully all possible results of an operation before he gives his "informed consent?" and (3) Should a patient be told of a disagreement about the diagnosis?

Terminal illness

One of the most complex problems facing physicians is whether to tell a patient his illness is terminal. While many doctors publicly advocate that patients should be told, many also try to suggest the circumstances under which he should not be given this information. However, Glaser observes that since "69 to 90 percent of doctors favor not telling their patients, rather than making a separate decision for each patient, it appears that most doctors have a general standard from which the same decision flows for most patients--that he should not be told."[1] Hilton mentions that while only sixty percent of physicians surveyed a few years ago would tell a patient he was terminally ill, ninety percent would want to be told if they were the patient.[2] Glaser gives some plausible reasons for the decision not to tell: "Few doctors get to know each terminal patient well enough to judge his desire for disclosure or his capacity to withstand the shock of disclosure. Getting to know a patient well enough takes more time than doctors typically have. . . . Even when a doctor has had many contacts with a particular patient, class or educational differences or personality clashes may prevent effective communication."[3]

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[1] Barney G. Glaser, "Disclosure of Terminal Illness," in Patients, Physicians and Illness: A Sourcebook in Behavioral Science and Health, ed. by E. Gartley Jaco (2nd ed.; New York: The Free Press, 1972), p. 204.

[2] Bruce Hilton, "The Truth? Or Something Less?" The Houston Chronicle, October 22, 1973, sec. 4, p. 3.

An interview with the chaplains on October 12, 1973, at St. Joseph revealed that the patients frequently are unable to say whether they have been told the seriousness of their illness. The chaplains explained that the emotional barriers sometimes prevent the patients from fully comprehending what the doctors say; sometimes the patients deliberately forget; and frequently the doctor himself is emotionally unable to be completely frank and therefore satisfies his responsibility by using vague or ambiguous terms.

Hilton states that telling is not a medical decision and the doctor could be doing harm by his half-truth:

> Some students of the psychology of seriously ill patients, for example, say that the patient nearly always knows, and that the failure of doctors or relatives to talk about it creates a barrier of silence which further isolates the victim.[4]

The surgeons and patients surveyed in this study seemed to indicate a desire for the truth.

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[3] P. 204.

[4] "The Truth? Or Something Less?" sec. 4, p. 3; for an in depth study of the psychology of the terminally ill, see On Death and Dying by Elisabeth Kubler-Ross (London: The Macmillan Company, 1969).

The patients were asked directly, "Would you want to know if you had a terminal illness? That is, do you think your doctor should tell you, if you are going to die?" Fifty-six patients gave a definite affirmative answer; the next most frequent response was given by eighteen patients, "if my family wanted me to know"; only six people gave a definite "no," and seven "would leave that up to the doctor." One patient felt that she would be "deprived" if the doctor failed to tell her and her immediate family, but thought the decision belongs to the doctor, not the family. Several people, however, saw no reason that the patient's family should be told unless the patient himself suggested it. Some spoke of the doctor's obligation to tell the patient; but those who disagreed did so from a personal viewpoint. For example, one patient stated that her family would have to make the decision whether or not to tell her because "if I knew how sick I was, I would probably give up." She characterized herself as a "worrier" who cannot watch some television programs because she feels "so sorry for someone who is sick."

However, contrary to what the previously mentioned authors wrote, the patients interviewed who were being treated for cancer were not so quick to give any kind of response, especially a "yes" answer. The number is not sufficient, though, to warrant any kind of generalization. One young mother of a beautiful, bright, and very active five-year-old son who was born with a noncorrectable internal defect gave a candid description of how and when she was told that her son would have a very short life span. She rejected the information and each time an operation was performed, she was hopeful. She was hesitant to hear what each surgeon reported, but said she finally has accepted the fact that her son will die. During the interview, she seemed cheerful and pleasant, while her son played hide-and-seek and wanted to help in the discussion.

Six of the surgeons stated that always, or almost always the patient should be told of his terminal illness. However, ten of them replied "sometimes" to the question. One doctor aptly remarked "How does one always know?" When questioned about who should make the decision to tell the patient, the physicians responded in a variety of ways. One explained by saying "I feel responsible to tell the patient his illness is quite serious and potentially fatal, and the patient asks for more details." All of the doctors accepted the major responsibility but many considered that the family and patient helped him to decide whether or not to tell all of the truth. Observation, however, tends to support the theory that the patient's family makes that decision. Certainly if the family requests the doctor not to tell the patient, he rarely goes against their wishes. One patient's wife wanted "to know everything" after her husband's operation but did not want her husband told "everything." These decisions by the family to withhold information from the patient might be selfish in nature. How much easier it is to assume a cheerful attitude if the patient remains in ignorance than to have to face the truth with the patient. Thus the problem remains: to whom does the physician owe the greatest obligation or allegiance, the patient or the patient's family?

Informed consent

Another serious communication problem confronting the surgeon is in acquiring the patient's consent to an operation. One prominent surgeon, Dr. Denton Cooley, stated that the problem of informed consent was "our greatest problem if we are to continue treating patients as we have in the past."[5] How much and under what condition should a patient be told before he gives his written consent?

Hilton gives a not uncommon example of part of the problem when he relates the following incident:

> The patient was already groggy from his preoperation sedative when the nurse noticed that he had given consent only for a biopsy—not for the major lung surgery which would have to follow immediately if the growth proved to be malignant.
>
> "Oh yes," the surgeon said when the nurse finally caught up with him. "I did not tell the patient anything except that he'd have a biopsy. I didn't want to upset him. But you can go ahead and get him to sign the consent form now."[6]

Sometimes the problem is merely a matter of forgetfulness; sometimes it is deliberately an attempt to keep the patient uninformed and thus unalarmed; and sometimes it is a matter of ineffective communication. According to one of the nurses in the outpatient clinic at St. Joseph Hospital, some of the resident doctors do not understand the importance of obtaining the proper consent for each operation and the nurses assume the responsibility of ascertaining that it has been accomplished before the patient is sent to surgery.

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[5] Private interview held during Grand Conference at St. Joseph Hospital, Houston, Texas, November 3, 1973.

[6] "The Truth? Or Something Less?" sec. 4, p. 3.

Hilton clarifies the problem when he states that the law has entered the debate and seems to be moving in the direction of the patient's right to know:

> Specifically, several recent appeals court decisions seem to have discarded the old standard for "informed consent" necessary for undertaking a new procedure or treatment. The requirement has been that a physician disclose the facts and risks which a reasonable physician would disclose under similar circumstances--in other words, standard medical practice, determined by other doctors.
>
> Now, in a few states, courts have said that the standard should be what the reasonable patient would want to know. The definition of informed consent seems to have moved, in those states, out of the hands of the physician and into the patient's.[7]

One attempt to solve this problem has resulted in various "informed consent forms." Specific forms are available for obtaining permission to perform specific procedures. Sometimes the patient has several to sign. A general authorization for the surgeon to operate which is used at St. Joseph Hospital appears as Appendix C. Notice that the hospital tries to prepare for several contingencies. The crux of the authroization can be divided into three areas. First, the patient agrees that he has been informed of why the operation "is considered necessary and its advantages and possible complications, as well as possible alternative modes of treatment." Furthermore, the explanation should be given by "physician or surgeon." Second, the patient authorizes a specifically named surgeon "to perform, under any anesthetic deemed advisable, the operation stated above and also to perform such additional procedures as may be held to be therapeutically necessary on the basis of findings in the course of the operation." Third, the patient agrees that "any tissues surgically removed may be disposed of by the surgeon or the hospital in accordance with their accustomed practice."

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[7] Ibid.

Obvious possible legal entanglements could result from such a general form. One example might be the interpretation of allowing residents to perform the operation that a private surgeon has been authorized to perform. Of course, the private surgeon is in charge, but how much can he allow his assistant to do and still be considered as performing the operation himself? The surgeons do not see this as a problem but a patient who is unaware of the medial team concept and the responsibilities of a teaching hospital might see this as more serious. A good example was observed when a resident working with a private surgeon introduced himself to the private patient about to undergo a major operation, as "one of your doctors." The patient immediately became upset and angry because he had arranged for one of the top surgeons to perform this operation and he "didn't want to be the subject of any experimentation!"

The most serious problem, however, is inherent in the patient's statement that the reasons for the operation, possible alternative modes of treatment, and advantages and possible complications have all been explained to him by his doctor. Is this information advisable, or even possible, in all cases? The surgeons were asked if they thought a patient must comprehend fully all possible results of an operation before he gives his informed consent? Seven answered "yes"; six answered "no"; and two said "sometimes, but not always."

One of the doctors commented that "it is difficult to achieve," and it should be "all common results" rather than "all possible results." Another, who had given an emphatic "no" to the question, said it was impossible and the patient should not be told of every possible result. One surgeon refused to answer in the affirmative or negative by explaining that it is impossible.

The law, however, does set some guidelines. One of the earliest decisions, Schloendorff v. Society of New York Hospital (211 N.Y. 125, 129-30, 105 N.E. 92,93 [1914]), established that "every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assult, for which he is liable in damages."

In the Nebraska Law Review, Arthur J. Shartsis gives a comprehensive review of the legal interpretations that have been associated with obtaining the informed consent of the patient.[8] The principle has been firmly established that the consent must be "informed" or it is not consent at all. Some of these problems have been settled in later court decisions. Shartsis cites cases that have been interpreted to mean that proper disclosure of risks does not always denote exhaustive disclosure. For example, (1) where risks ought to be common knowledge, they need not be disclosed; (2) the physician is not required to disclose risks which the patient knows because of previous experience with the treatment to be administered; and

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[8] "Informed Consent: Some Problems Revisited," Nebraska Law Review LI (1972), 527-51.

(3) where an emergency exists, the physician need not obtain the consent of the patient for operative procedures. Nevertheless, as Shartsis observes, "Those aspects of informed consent which have not been given sufficient consideration relate to: (1) acceptable justifications for failure to disclose material risks; (2) whether the proper cause of action is in battery or negligence; and (3) problems arising from difficulties in the communication process between physician and patient."[9] It is this last which should concern the student of oral communication.

Difference in opinions

Related to the surgeon's attitude toward the patients' comprehension of their diagnosis and treatment is the surgeon's solution to the problem of differing opinions between two consulting physicians concerning the treatment of a patient. The surgeons were asked to respond to the possibility of such a difference of opinion. First, the question was asked, "When a disagreement exists between you and another consulting physician as to the best treatment for your patient, do you discuss this with the patient?" The question itself was interpreted several ways that evoked a heated discussion concerning ethics, circumstances, and patients. The answers recorded, however, are five "always," eight "sometimes," and three said "never." The second question was dependent upon the first. If they answered "always" or "sometimes," they were asked to describe the reason for discussing the difference with the patient.

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[9] Ibid., 529.

Six doctors gave as their answer "I want the patient to understand as much as possible about his case." Three surgeons answered "I let the patient decide for himself which should be done," and three others said "I think the patient should realize that no doctor has all the answers." One doctor said he would try to influence the patient toward his own view, but if there were legitimate alternatives then it was up to the patient to decide. Another commented that the "patient should share a knowledge of the difficulties of his case and his doctor's approach and thinking."

The controversy revolved around the ethics of the doctors. For example, if the patient had called the second doctor into the case then the consultant has some obligation to discuss the case with the patient. If the second doctor was brought into the case by the patient's private physician, then the consultant reports to that physician. However, the surgeons disagreed over the position of the second doctor who might strongly feel that the patient's private doctor was in serious error. To whom does the consultant owe his allegiance? If the patient directly asks the second doctor for his opinion, how much should he say if he disagrees with the doctor who requested his consultation? These are questions that depend upon the surgeon's personal values and ethics. Fortunately, if the doctor asked for a consultant, then he usually has enough respect for the consultant's ability to weigh his advice very carefully.

Summary

In summary, both the surgeons perceive themselves to be the primary source of information for their patients and the patients indicate a heavy reliance on them as a source. The doctors generally agree that it is at least helpful if not essential that the patient comprehend his diagnosis and method of treatment. Nevertheless, the surgeons are not always completely willing to disclose all possible information to the terminally ill, to some patients scheduled for operations, and under some circumstances, when a difference of opinion between doctors exist. Otherwise, the doctor feels the patient has a right to know.

CHAPTER SIX

PATIENTS' DESIRE FOR INFORMATION

The patients' responses to questions concerning their desire for information tend to confirm Cartwright's observation that "patients differ not only in the level of their interest in their illness and treatment, but also in their ability to understand and accept information."[1] For example, one fifty-five year old man repeatedly commented that the surgeon volunteered all the information he needed "in a gentle way" and that he wanted to know "only what is necessary" about his illness. The physician never "alarmed" him. When he was asked if he would want to know if he had a terminal illness, he replied "no." On the other hand are numerous examples of patients wanting the doctor to be "frank" and "not pull any punches."

The following factors of the patient's desire for information are considered in this chapter: (1) the patient's satisfaction with the information he obtains from the doctor concerning his illness and treatment; (2) the kinds of information he wants to know about his problem; (3) his comprehension; and (4) the passivity of the patient in his desire for information.

Satisfaction with Information

Of the eighty-seven patients answering a question concerning their satisfaction with the information they received, almost eighty percent reported that they had been able to find out all they wanted to know about their condition, treatment, and progress. Fifteen patients responded "no" to the question and another four said that they had received this information "most of the time." When the physicians were asked if their patients were able to find out everything they wanted to know, only two failed to answer with a positive "yes." These two merely admitted to not knowing. Several, however, qualified their answers with "from me" and one went even further to say "not often enough from other physicians."

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[1] Human Relations and Hospital Care, p. 73.

Kinds of Information

Most of the patients interviewed, as patients of surgeons, either had had an operation or were faced with that possibility. Therefore, the kinds of information they might want concerned the actual operation as well as the diagnosis and medical treatment. Thus the question was asked, "Are you mainly interested in how your problem is going to affect you, or do you like to know the mechanical details as well?" Over fifty-six percent of the patients responding to this question were interested in the "actual mechanical details," as well as how their problem would affect them. However, one-third wanted to know only how the operation or illness would affect them, and the responses of another eight suggested that it did not matter what the doctor told them so long as he helped them. A comparison of the answers between clinic and private patients revealed approximately the same percentages for both groups.

The physicians also were asked to describe their patients' interest in details. Thirteen of the surgeons responded that their patients only wanted to know how their problem would affect them. Only three felt that they would want to know the mechanical details as well. These results tend to support the assumption that doctors underestimate the patients' desire for explanations. However, if the surgeons had been given a choice of responses according to percentages, such as the percentage of patients who want to know details, their predictions might have been more accurate. The estimate of one surgeon who did give his own percentages was the reverse of patients' responses. He stated that "66 2/3%" wanted to know mainly how they would be affected and only "33 1/3%" would want the mechanical details also.

Later, however, the surgeons were given an opportunity to estimate "what percentage of patients want to know the details of the prescribed treatment." Although this question concerns "details" in relation to prescribed treatment, it seems safe to assume a significant relationship with the earlier questions. No overwhelming majority of surgeons agreed in these responses. Only six doctors accurately predicted that between fifty-one and seventy-five percent of patients want details; four answered between zero and five percent; two answered between six and twenty-five percent, and another two said between twenty-six and fifty percent; and three surgeons overestimated the percentage as being between seventy-six and ninety-five percent. Perhaps the patient was accurate when he commented that his "doctor said everything was all right but he didn't tell me *what* is all right!"

Passivity of Patients

Some patients accept whatever the doctor wants to tell them without asking for more information. Others ask, but feel they have to explain by making such comments as "I'm just nosey, I guess." Richard Blum discovered a difference in the diffidence and passivity of patients who are in the hospital and those who have been released from the hospital:

> As striking as the virulence of criticism of hospitals by patients who are not in the hospitals is the absence of complaints from people while they are in the hospital. While two-thirds of *released* patients are bitter in their comments about what happened to them when they were patients, practically no hospitalized patient will raise his voice in direct criticism. . . .
>
> Most of the 4 percent who did gripe and grumble restricted their complaints to impersonal targets. They singled out the food, corridor noises, or visiting hours. They rarely said an unkind word about doctors, nurses, or aides. That is an amazing contrast to the criticisms of the released patients, nearly all of whom centered their ire on hospital personnel, doctors, nurses, and aides.[2]

He gave five reasons why the complaints were not made while the patient was in the hospital:

(1) Sickness is a silencer

(2) Sedated silence

(3) Quiet fear, i.e., the need to keep those he is dependent on as friends

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[2] *The Management of the Doctor-Patient Relationship*, p. 215.

(4) Shutting out doubt about the goodness of the doctor or nurses

(5) Being good, i.e., he is "not supposed to complain."[3] Some of the above reasons might help to explain the following results obtained in the interviews.

When the patients were asked, "Do you generally have to ask for information from your doctor or does he volunteer the information?" some of them were visibly hesitant. The ones who had been verbally praising the doctor were now unsure which answer could be interpreted as criticism of that doctor. Over half of the patients responded that the doctor volunteers all the information they want. The remaining patients were almost equally divided between two answers: twenty patients stated they had to ask for information and twenty-one said the doctor volunteers some information and they ask for the rest. The unwillingness to say they had to ask for information was supported with explanatory comments by those who admitted to asking, such as "I fish for information; I guess I'm just too nosey."

When the physicians were asked the same question, fifty percent of the group stated that they volunteer the information. Only three surgeons said that patients ask about their illness and treatment, while the remaining twenty-four percent said it depends on the patient and his illness. Perhaps the doctors are not listening when those patients ask. One surgeon commented that "many patients do not ask much; often several explanations must be given; [and this] may be the reason many M.D.'s do not go to that length." One of the three surgeons who had answered that patients ask for information clarified his response by adding that they ask "sometimes in a subtle way" and "the opening up of communication is up to the M.D." Another responded that "some patients are interested in their problems, others don't care." Perhaps the most candid answer was that it "depends upon [the] gravity of [the] condition, and the diagnosis, the stability of [the] patient, and whether the family knows or has expressed a desire."

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[3] _Ibid._, pp. 224-28.

The patients did not appear so passive, however, when asked if they want to know as much as possible about what is wrong with them. Seventy-one answered in the affirmative, which certainly supports the earlier findings that most patients want to know details of their treatment. Only four people gave negative answers; another four felt that, while they did not want to know all the details, one family member should be told as much as possible. However, eight patients did respond that "the doctor tells me what I need to know." Perhaps patients are not so much passive in their desire for information as passive in their quest for the information.

Summary

As a group, the patients sought to create the impression that their desire for information was being satisfied. They seemed to feel that any criticism would reflect on the medical ability of their physician, who is held in high esteem.

Some discrepancies exist in their answers when the responses are compared with one another. For example, fifty-three and one-half percent of the patients said the doctor "volunteers all the information I want." When asked if they find it easy to think of everything they want to ask while they are with the doctor, forty-two and one-half percent said that they did. However, that leaves fifty-seven and one-half percent of the patients who must not have received all the information they wanted since they thought of things they wanted to ask the doctor subsequent to his visit.

The patients' answers were evaluated according to their consistency. For example, the responses of the individual patient to the following three questions were compared:

(1) When you are ill, do you like to know as much as possible about what is wrong with you?

(2) Are you mainly interested in how your problem is going to affect you, or do you like to know the actual mechanical details as well?

(3) Would you want to know if you had a terminal illness?

The assumption is that if a person desires full knowledge of his illness and treatment, his answers would consistently reflect that desire. Only thirty-five of the patients were completely consistent. That is, these patients answered "yes" to the first question, "details" to the second, and gave a positive "yes" with no qualifications to the third question. The questions were not asked consecutively during the interview.

The relationship between the patient's being able to obtain all the information he wants and his perception of the doctor's ability and willingness to communicate is presented in Table I. The results reveal that those patients who were dissatisfied with their ability to find out all they wanted to know were more likely to have asked for information than to have had it volunteered. The dissatisfied patients also were more likely to have perceived the doctor as being too busy for complete freedom of discussion. Nevertheless, the majority of patients were satisfied with their ability to obtain information which was volunteered by the doctor in simple language. They found the doctor accessible and easy to talk with.

TABLE I

SATISFACTION WITH INFORMATION AND PERCEPTION OF DOCTOR'S COMMUNICATION

Perception of Doctor's Communication	Satisfaction with Information		
	Since you have been under the care of your present doctor, have you been able to find out all you wanted to know about your condition, your treatment, and your progress?		
	Yes (%)	No (%)	Mostly (%)
Patient asked for information	4 (4.9)	12 (14.6)	0
Patient told information	42 (51.2)	2 (2.4)	3 (3.7)
Both asked & told	17 (20.7)	2 (2.4)	0
Explanations by doctor given in:			
Medical terminology	8 (10.0)	4 (5.0)	0
Simple language	43 (53.8)	9 (11.3)	1 (1.3)
Both, but clear	11 (13.8)	4 (5.0)	0
Description of doctor as:			
Easy to talk to	57 (68.7)	5 (6.0)	1 (1.2)
Usually busy	7 (8.4)	8 (9.6)	0
Impossible to have discussion with	1 (1.2)	4 (4.8)	0

CHAPTER SEVEN

THE PHYSICIAN AS COMMUNICATOR

The physician clearly is aware of the importance of communication in his relationship with his patients. How effective he is as a communicator may depend upon his use of clear language, his ability to develop rapport with his patients, and how accessible he is for discussions with his patients.

Accessibility and Freedom for Discussion

The surgeons were asked to choose the following descriptions which best describes them:

A. My patients find me accessible and ready for discussions.

B. Because of my busy schedule, it is not possible to talk to my patients as much as I like.

C. For various reasons, I am rarely asked questions by my patients.

With no exceptions, the surgeons saw themselves as accessible and ready for discussions. Although the questions are not mutually exclusive of each other, and it is possible that all three choices could be checked, no one was willing to admit to the "B" or "C" statements. Their private patients, with one exception, agreed that "it is easy to talk to the doctor and to ask him questions," but the clinic patients told a different story. Approximately thirty percent said that "the doctor is usually busy and it is not possible to talk to him as much as I like"; another ten percent stated that "it is not possible to have a really helpful discussion with the doctor." Whether these patients are accurate in their judgment is of little concern; the results are the same. That is, forty percent of the clinic patients perceive the doctor as being unable to communicate with them for various reasons.

The explanation for these results does not seem to be a cultural or racial matter. That is, the ratio of Whites, Blacks, and Mexican-Americans viewing the doctor as easy to talk to or as impossible to engage in helpful discussion was approximately the same. The reason for the difference between private and clinic patients may be lack of identification with a particular doctor by the clinic patient.

The problem, therefore, may not be in actual accessibility or willingness to communicate, but in convincing the patient of that accessibility. One patient felt it was impossible to have a helpful discussion because "you feel you are taking up too much of their time and they are so busy with other, perhaps more important, problems." Several attributed this barrier to their own reluctance to ask questions, but one patient responded that "you can talk to them but you don't get the answers you need!"

The majority of patients described the physician as being easy to talk to and not too busy; nevertheless, the results of the following question indicate some difficulty in communication: "Do you find it easy to think of all the things you want to ask while you are with the doctor, or do you frequently remember questions afterwards?" Only one patient voluntarily stated that his doctor's manner made it easy for him to remember everything he wanted to ask. Of the eighty patients answering this question, forty-six found they remembered things they wanted to ask after leaving the doctor. Many of the remaining thirty-four explained that they wrote down their questions prior to seeing the doctor. That this is necessary also indicates some degree of lack of ease.

The physicians, on the other hand, tried to anticipate the attitude of their patients by responding to "How free do patients feel in asking questions concerning their illness?" The surgeons were divided in their responses to the question. Of the possible responses listed, eight of the surgeons checked "completely free" and nine felt the patients to be "hesitant." No one gave either of the two remaining choices: "Rarely ask questions" or "Never ask questions; I volunteer the information." These answers might be considered somewhat at variance with the earlier responses as to whether patients ask for information or the doctor volunteers the information. However, the explanation seems to be that while the patients might "feel free" to ask questions, they usually do not and the doctor volunteers the information.

Language Use

That the physician and patient frequently do not share a common terminology seems obvious. Thompson and Insalata found one of the barriers to communication between attorney and client to be inadequate referential meanings.[1] In an effort to determine whether the physician attempts to overcome this same problem, the surgeons were requested to respond to the following question: "When discussing the patient's condition and treatment with him, do you generally use medical terms or do you try to simplify your language?" Obviously this is a leading question which directs the physician to the "correct" response. All did respond that they used simplified language in their explanations. A few suggested that medical terms sometimes are used and then clarified with simple language.

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[1] Pp. 28-29.

Their patients, for the most part, agree with this view. While sixty-five percent stated that the doctor used "simple language that always is clear"; another twenty percent qualified their responses as "some medical language but clear enough for me to understand"; and the final fifteen percent stated that the doctor used "medical terms that I don't always understand." Ironically, fourteen percent of those who said that clear and simple language was always used added "because I ask" for explanations when they were not forthcoming. Some people, however, seem to have a reluctance to admit that they do not understand the terminology. Another patient's expectations of the doctor's use of language was rather low as he qualified his answer with "as simple as he can." Unfortunately, what constitutes "simple" versus "medical" language may be ambiguous; and what a doctor uses certainly varies with different patients and in different circumstances. For example, two of the patients insisted upon naming a doctor who used simple explanations and one who used medical terms that they did not understand. Each of the two patients named the same two doctors, but as opposite examples!

Maintaining Rhetorical Distance

Unlike members of other professions, physicians show little, if any, desire to develop personal relationships with their clientele as a means of improving or enhancing their communication. Actually, the opposite seems to be true. The physician maintains a certain degree of distance as a means of enhancing his mystique. A patient who suggests that the physician join him in a social activity might be encouraged initially by the doctor's response. However, when the patient issues a specific invitation, he discovers the doctor to be evasive or with another obligation. One surgeon explained that a person is unlikely to have confidence in his doctor if he witnesses his weaknesses in a social setting. Notice for example, that when interviewed, no patient gave any response that indicated any physician had been selected because the patient knew him personally.

Another means of providing that distance which seems to be necessary to achieve a charismatic influence on the patient is the physician's subtle insistence on the use of a title for himself which is comparable to that given the President. He is referred to as "the doctor," or "Dr. Smith." Exceptions, of course, do exist, but the occurance of a personal relationship between the physician and patient is infrequent.

Paradoxically, the physician frequently refers to his patients by their first names and sometimes even terms of endearment. Of the patients interviewed, thirty-six percent stated that the doctor usually calls them by their first name, while no one said they addressed the doctor by his first name. When asked how they preferred to be addressed by the doctor, forty-eight out of seventy-five responded that "It does not matter how he addresses me," and another seventeen preferred that he use their first name.

This seeming paradox can be resolved in terms of the relationship desired by both the patient and doctor. For example, many patients seemed pleased to be able to say the doctor used their first names. This indicated to them his personal concern with their individual welfare. One patient emphasized that the more personal the doctor was, the more he liked it. Another replied that the use of his first name made him feel more relaxed. A clinic patient offered her explanation of the reason the doctor addressed her with terms of endearment such as "honey," "sweetheart" or "dear." She said that he used the terms in a "cold manner like he had forgotten my name, but still wanted to make you feel comfortable." Thus the patient seems to associate the use of his first name with the doctor's concern for him.

The physician, on the other hand, enjoys in a practical manner the distance he places between himself and others not sharing the same mystique. Cartwright observes that physicians "often seem to discourage patients from asking questions and they sometimes use the patients' feelings of respect and deference to evade the discussion."[2] Somehow, it would be easier to interrupt or disturb John Smith than Dr. Smith.

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[2] P. 99.

CONCLUSION

In essence, the physicians differ only slightly from other professionals in talking with their colleagues. As members of a group perceived by both nonmembers and members as having high status, they utilize and require this esteem to gain acceptance for their theories. Nonmembers seem to have less credibility and are rarely asked to speak on any subject. The surgeons, for the most part, are unwilling to accept criticism, which may be a personality factor associated with their profession.

The physicians, while knowledgeable about their subject matter, spend little time on the actual preparation of their formal speeches. They rely on their experience more than on thorough research. Their major preparation is in providing visual material which is used primarily as a visible manuscript for the audience.

The resident surgeons are, for the most part, well organized in their presentations and spend relatively more time on library research than do the private staff physicians. However, their delivery suffers from their nervousness, but usually improves as the residents gain status in the medical hierarchy. The private staff physician seems to use his experience to compensate for any weakness in organization and other formal preparation.

Surgeons in a university affiliated hospital, such as St. Joseph Hospital, generally have available to them a tremendous amount of material for research, including medical libraries, and audio-visual departments willing to prepare movies, slides, charts, and graphs for speeches, as well as the records department to trace the history of patients. Unfortunately the surgeons' busy schedules, or at least their rationalizations concerning their time, preclude taking advantage of all these materials.

One physician writes that American medical education's program to produce a doctor-scientist has a "nasty side effect: it takes incoming medical students who are interested in people, and transforms them into doctors interested in diseases."[1] The result, is that the doctor, his years of training over, makes the following discoveries:

> First, he finds that he must practice a great deal of unscientific medicine--dealing with the seventy percent of his patients who have no demonstrable illness, but varying complaints. This calls for behavioral training which he almost certainly lacks. Second, he discovers that his training is rapidly outdated, but the refresher courses run by the university doctors are generally abstruse, heavily scientific, and lacking the practical details on patient care that he needs.[2]

The analyses, observations and responses given during the interviews in this field study do not support this judgment.

The patients interviewed, for the most part were satisfied with their communication with their surgeon. Explanations for this satisfaction were such characteristics as the doctor's "bedside manner," best illustrated by his demonstration of concern for them individually. Dissatisfaction usually resulted from the doctor's failure to keep appointments, but at the same time that this criticism was being voiced, the patient usually excused the doctor on the basis of him important, busy schedule. To do otherwise might permit dissonance in the patient, who would be admitting the doctor's unconcern for his own treatment.

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[1] Lewin, p. 52.

[2] Ibid.

The doctor accurately perceives himself as the greatest source of information to the patient. He gives verbal support to the principle that the patient has the right to know about his condition and treatment. Nevertheless, he seems to reserve the right to withhold such information that he considers would be detrimental to the best interests of that patient. The patient, on the other hand, generally reports a desire for all details when discussing his case with the physician. He seems willing, however, to wait for the surgeon to volunteer that information rather than to ask questions.

The physicians are prone to reinforce their prestige and authority with their insistence on the medical titles while using the patient's first name to indicate their personal concern for him as an individual. The patients are pleased with this demonstration of status. Unanimously, the surgeons perceive themselves to be completely accessible and open for discussion with their patients. The patients, however, do not always agree that this is true.

Although many jokes are made concerning physicians' use of medical terminology, the doctors try to dispel this notion. The patients generally agree that the doctor uses simple and clear language for his explanations.

The interviews and survey had certain fallacies. First, the sequence in which interviews were held plus the observer influence had some effect on the patients' responses. That is, the physician's awareness of an observer may have affected his communication; the patient's being interviewed immediately subsequent to his seeing the doctor may have resulted in more favorable than usual answers to the questions. Ideally, the communication between doctor and patient should be observed over a period of time. Whether permission to do this could be obtained is questionable.

Another problem lies in accurately determining how much knowledge the patient has prior to seeing the doctor, compared with the information he subsequently has, to determine the effectiveness of the physician's communication. The effectiveness, of course, might be influenced by certain emotional barriers held by an ill person.

The large number of satisfied patients participating in this study either creates a doubt as to the truthfulness in their responses or it tends to dispel the theory that doctors are being criticized for a lack of communication. Observation, however, tends to support the fact that the satisfaction is genuine, which means that most people accept with few questions what the doctor voluntarily tells them. If the patient is satisfied with the paternalistic role of the doctor, then why should the physician adopt any other manner in communicating?

In summary, the results of this study indicate that the patients are willing to accept the surgeon's title as sufficient credentials to obey his directives without question. By the same reasoning, the surgeons themselves often seem to expect their colleagues to accept their judgment without asking for documentation. While the doctors are less hesitant in admitting mistakes and controversies concerning treatment to their colleagues than to their patients, they effectively reason that the patients' awareness of such problems would be detrimental to the patients' welfare. The surgeons demonstrate confidence in their own judgment before their colleagues and their patients but many of them lack the fluency and ease of manner which usually accompany such self-confidence in their formal speaking.

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Interviews

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APPENDIXES

APPENDIX A

PATIENT'S QUESTIONNAIRE*

[Note: The numbers in paranthesis by each response indicate the number giving that response. Occasionally a patient checked more than one answer which accounts for the variation of total numbers in each question.]

Please fill in the following information:

Age ____________ Sex ____________ Occupation ____________________

1. Approximately how long have you been under the care of your present doctor?

(38) A. Less than one year
(36) B. 1-5 years
(5) C. 5-10 years
(3) D. Over 10 years

2. How did you select this physician?

(1) A. He is the one on call when I need to see a doctor
(6) B. He was recommended by a friend
(26) C. He was recommended by another doctor
(4) D. He was recommended by an organization or employer
(0) E. I knew him personally
(0) F. I heard him speak at a meeting or on the news
(0) G. I chose him at random

3. Have you had a doctor previous to your present one?

(67) A. Yes
(13) B. No

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*Some of the questions used are adapted from a questionnaire by Anne Cartwright in Human Relations and Hospital Care. (London: Routledge and Kegan Paul, 1964), pp. 229-238.

4. Would you recommend your previous doctor to a friend?

(62) A. Yes
(12) B. No
(1) C. Under some circumstances

5. If you answered no to the above question, which of the following best describes your reason?

(2) A. I don't think he is a good doctor
(1) B. He is never there when you need him
(2) C. He no longer practices medicine
(4) D. He is a good doctor but he never tells you what you want to know
(2) E. I don't like his office
(5) F. Any other reason (explain)

6. Since you have been under the care of your present doctor, have you been able to find out all you wanted to know about your condition, your treatment, and your progress?

(68) A. Yes
(15) B. No
(4) C. Most of the time

7. Do you generally have to ask for information from your doctor or does he volunteer the information?

(20) A. I have to ask
(54) B. He volunteers all the information I want
(25) C. He volunteers some information and I ask for the rest

8. From whom do you find out most of your information about your illness and treatment?

(75) A. My doctor
(13) B. My doctor's nurse
(1) C. My family
(0) D. Other people
(2) E. Someone other than these listed

9. When you are ill, do you like to know as much as possibe about what is wrong with you?

(72) A. Yes
(4) B. No
(8) C. The doctor tells me what I need to know
(4) D. One member of my family should be told as much as possible; I don't want to know all the details

10. Are you mainly interested in how your problem is going to affect you, or do you like to know the actual mechanical details as well?

(26) A. Mainly how it affects me
(44) B. Details
(8) C. It doesn't matter as long as the doctor helps me

11. When the doctors discuss your case with you, do they use medical terms or simple language that you and I can understand?

(12) A. Medical terms that I don't always understand
(16) B. Some medical language but clear enough for me to understand
(53) C. Simple language that is always clear

12. Do you find it easy to think of all the things you want to ask while you are with the doctor, or do you frequently remember questions afterwards?

(34) A. All things while I am with the doctor
(46) B. Afterwards
(2) C. Other

13. Here are three descriptions of doctors; which one most nearly describes your experience with the doctor?

(63) A. It is easy to talk to the doctor and to ask him questions
(15) B. The doctor is usually busy and it is not possible to talk to him as much as I like
(5) C. It is not possible to have a really helpful discussion with the doctor. (Give examples)

14. Does your doctor discuss your case with anyone other than yourself?

(58) A. Yes, with other doctors and nurses
(17) B. Yes, with members of my family
(0) C. Yes, with clergymen
(15) D. No
(1) E. Other

15. With which of the following would you permit your doctor to discuss your case?

(74) A. With medical personnel
(60) B. With members of my family
(15) C. With my clergyman
(25) D. With my friends
(7) E. With no one unless he asks me

16. How does the doctor address you when he is discussing your case with you?

(37) A. By my first name
(15) B. By only my last name
(36) C. By a title and my last name (such as Mr., Mrs., or Capt.)
(3) D. By terms of endearment such as honey, sweetheart, dear, etc.
(0) E. By family names such as Mama, Dad, Son, Pops, Grandpa, etc.
(2) F. By a nickname

17. Which would you like for your doctor to call you?

(17) A. By my first name
(10) B. By a title and last name
(48) C. It does not matter how he addresses me

18. How do you address your doctor?

(27) A. I call him "Doctor"
(54) B. I call him Dr. ________
(0) C. I call him by his first name

19. Would you want to know if you had a terminal illness? That is, do you think your doctor should tell you if you are going to die?

(56) A. Yes
(6) B. No
(6) C. I would leave that up to the doctor
(18) D. If my family wanted me to know

20. Can you suggest any way which your doctor might improve?

APPENDIX B

PHYSICIANS' QUESTIONNAIRE*

PLEASE NOTE: Please clarify, explain or make additions to any answers if you think it is necessary for more accurate answers. If you do not wish to answer a question, please mark X over the question.

1. How many years have you been an M.D.?

(7) A. 1-5 years
(3) B. 6-10 years
(4) C. 11-20 years
(2) D. 21-over years

2. In your opinion, what percentage of your patients usually understand the diagnosis and treatment of their illness?

(0) A. 0-5%
(1) B. 6-25%
(2) C. 26-50%
(4) D. 51-75%
(6) E. 76-95%
(5) F. 96-99%

3. Are most patients able to find out all they want to know about their condition, treatment, and progress?

(14) A. Yes
(0) B. No
(2) C. I don't know

4. From whom do patients obtain most of their information about their condition, treatment, and progress?

(15) A. Their physician
(0) B. Nurses
(0) C. Other patients
(1) D. Their families

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*All surgeons did not answer all questions.

5. In general, do patients ask about their illness and treatment, or do you volunteer the information? [Some checked more than one response.]

(3) A. Patients ask
(9) B. I volunteer
(6) C. It depends on the patient and his illness (If possible, give brief example.)

6. How free do patients feel in asking questions concerning their illness?

(8) A. Completely free
(9) B. Hesitant
(0) C. Rarely ask questions
(0) D. Never ask; I volunteer information

7. Are most patients mainly interested in how their illness will affect them or do they want mechanical details as well?

(13) A. Mainly how it will affect them
(3) B. Mechanical details also

8. Do your hospitalized patients obtain most of the information concerning their illness and treatment from you [Some checked more than one answer.]

(9) A. during office visits before or after hospitalization.
(12) B. during your hospital visits.
(0) C. over the telephone.

9. When discussing the patient's condition and treatment with him, do you generally use medical terms or do you try to simplify your language?

(0) A. Medical terminology
(16) B. Simplified language
(2) C. Both

10. In your own opinion, which of the following best describes you? (Please check only one.)

(16) A. My patients find me accessible and ready for discussion.
(0) B. Because of my busy schedule, it is not possible to talk to my patients as much as I like
(0) C. For various reasons, I am rarely asked questions by my patients.

11. What percentage of patients want to know the details of the prescribed treatment?

(4) A. 0-5%
(2) B. 6-25%
(2) C. 26-50%
(6) D. 51-75%
(3) E. 76-95%
(0) F. 96-100%

12. Which of the following best describes the necessity of a patient's comprehension of the diagnosis?

(0) A. A hindrance
(0) B. Unnecessary
(5) C. Helpful but not essential
(12) D. Essential

13. Should a patient be told of his terminal illness?

(6) A. Always or almost always
(10) B. Sometimes
(0) C. Never

14. Who should make the decision to tell a patient that his illness is terminal?

(11) A. The physician
(3) B. The family
(7) C. The patient makes that decision when he asks

15. Do you think a patient must comprehend fully all possible results of an operation before he gives his informed consent?

(7) A. Yes
(6) B. No
(2) C. Sometimes but not always

16. In your opinion, from which of the following sources do most people receive most of their information concerning illnesses and their treatment?

(7) A. Their doctor
(0) B. Nurses
(1) C. Newspapers and magazines
(6) D. Friends or family
(1) E. Television programs

17. Approximately how many times a year do you give speeches, lecture, or participate in panels for nonmedical groups?

(3) A. None
(6) B. 1-2
(4) C. 3-5
(1) D. 5-10
(3) E. Over 10

18. Of these public speeches you make, how many are nonmedical in subject matter?

(0) A. All
(0) B. Most
(2) C. A few
(11) D. None

19. Approximately how many speeches, lectures, or formal discussions (such as in panels and symposiums) a year do you give to your colleagues? This includes conventions, composed of professional medicine men.

(3) A. None
(2) B. 1-2
(4) C. 3-5
(4) D. 5-10
(3) E. Over 10

20. Have your patients ever indicated that you should not discuss their illnesses and treatment with anyone other than medical personnel?

(5) A. Yes
(8) B. No
(6) C. Some have

21. After an operation, to whom do you explain the results in detail?

(9) A. Relatives and friends who are present
(5) B. One family member only
(12) C. The patient, as soon as he is capable of understanding

22. Which of the following best describes most of the families of your patients?

(2) A. Hinders the carrying out of my orders
(13) B. Helps in seeing that my orders are carried out
(0) C. A nuisance
(2) D. Neither a help nor a nuisance

23. To whom belongs the responsibility of educating the public concerning medical research and its findings?

(15) A. All doctors
(0) B. Only the AMA
(1) C. Journalists
(1) D. There is no need to educate the public in these matters

24. When a disagreement exists between you and another consulting physician as to the best treatment for your patient, do you discuss this with the patient?

(5) A. Always
(8) B. Sometimes
(3) C. Never

25. If you answered A or B to the above question, which of the following best describes your reason for doing so?

(3) A. I let the patient decide for himself which should be done.
(6) B. I want the patient to understand as much as possible about his case.
(3) C. I think the patient should realize that no doctor has all the answers.
(0) D. Other (Please explain.)

APPENDIX C

AUTHORIZATION FOR SURGEON TO OPERATE

A.M.
Date______________19__Time___P.M.

I, _________________________, hereby consent to the surgical
(Name of Patient)

procedure known as: ____
(State nature of operation or procedure, as: "an operation to remove Appendix")

I certify that the reasons why it is considered necessary, its advantages and possible complications, as well as possible alternative modes of treatment have been explained to me by ____________________,
(Name of Physician or Surgeon)

& in light of this information the undersigned authorizes

____________________ to perform, under any anesthetic deemed advisable,
(Name of Surgeon)
the operation stated above and also to perform such additional procedures as may be held to be therapeutically necessary on the basis of findings in the course of the operation. I also authorize that any tissues surgically removed may be disposed of by the surgeon or the hospital in accordance with their accustomed practice.

WITNESS: ________________________ Signed_________________________
(Patient or Nearest Relative)

WITNESS: ________________________ _________________________
(Relationship)

Authorization must be signed by the patient, or by the nearest relative in the case of a minor; or when the patient is physically or mentally incompetent.